SCIP Strengthening Communities through Integrated Programming

Agreement No. CA No. 656-A-00-09-00134-00

FY2015

Annual Report: 1 October 2014 – 30 September 2015

CONTENTS

LIST OF TABLES AND FIGURES

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
APEs	*Agentes Polivalentes Elementares* ("Barefoot doctors")
ART	Anti-Retroviral Therapy
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behavior Change Communication
CBD	Community-Based Distribution
CBOs	Community-Based Organizations
CEOC	Complete Emergency Obstetric Care
CLCs	Community Leadership Councils or Village Health Committees
CL	Community Leader
CLL	*Conselho Local da Localidade* (Local Leaders' Council)
CLTS	Community-Led Total Sanitation
CMC	Co-Management Committee
CoC	Continuum of Care
COSACA	Concern Oxfam Save the Children CARE (Disaster Relief NGO consortium)
CYP	Couple Year Protection
DPS	*Direcção Provincial de Saúde* (Provincial Directorate of Health)
DPSMAS	*Direcção Provincial da Mulher e Acção Social* (Provincial Directorate of Social Welfare)
EPI	Expanded Program on Immunization
FP	Family Planning
GAAC	*Grupo de Apoio e Adesão Comunitário* (Community HIV Assistance and Adherence Group)
HBC	Home-based care
HF	Health Facility
HTC-C	Community based HIV Testing and Counseling
ICAP	International Center for AIDS Care and Treatment Programs- Columbia University
IEC	Information, Education, Communication
IUD	Intrauterine Device
JFM	January, February & March
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MUAC	Mid-Upper Arm Circumference
MWH	Maternal Waiting House
NGO	Non-Governmental Organization
OND	October, November and December
OVC	Orphans and Vulnerable Children
OVP	Other Vulnerable Populations also called Priority Populations (mobile populations, OVCs, chronically ill, partners and children of chronically ill, partners and children of HIV+ pregnant women)
PACOV	*Plano de Acção de Crianças Orfãos Vulneraveis* (Action Plan for OVCs)

PGB *Programa Geração Biz*
PMTCT Prevention of Mother-to-Child Transmission
PNC Pre-Natal Consultations
PRN *Programa de Reabilitação Nutricional* (Nutrition Rehabilitation Program)
PSI Population Service International
PwP Prevention with Positives
RSLG Rotating Savings and Loans Groups
SCIP Strengthening Communities through Integrated Programming
SDAE *Serviços Distritais de Actividade Económico* (District Economic Activity Services)
SDETC *Serviços Distritais De Educação, Tecnologia & Cultura* (District Education, Technology and Cultural Services)
SDP Service Delivery Point
SDSMAS *Serviços Distritais de Saúde, Mulher e Acção Social* (District Health, Women and Social Welfare Directorate
SDPI *Serviços Distritais de Planeamento e Infraestruturas* (District Public Works Directorate)
SRH Sexual and Reproductive Health
STIs Sexually Transmitted Infections
TA Technical Assistance
TBA Traditional Birth Attendant
TDA *Tratamento de Desnutrição em Ambulatório*
USG United States Government
WASH Water, Sanitation, & Hygiene
YFC Youth Farmer's Clubs

1. PROJECT INFORMATION

Project Title		Strengthening Communities through Integrated Programming (SCIP)
Prime		Pathfinder International
Partners[1]		CARE International CLUSA World Relief
Cooperative Agreement No.		656-A-00-09-00134-00
Project Dates		October 2009 – December 2015
Project Funding		$52,550,000 USD
Reporting Period		October – December 2014
Contact Person	**Name**	Luc van der Veken, Chief of Party
	Tel and Email	+258 82 3257100 lvanderveken@pathfind.org. Lvanderveken@scipnampula.org

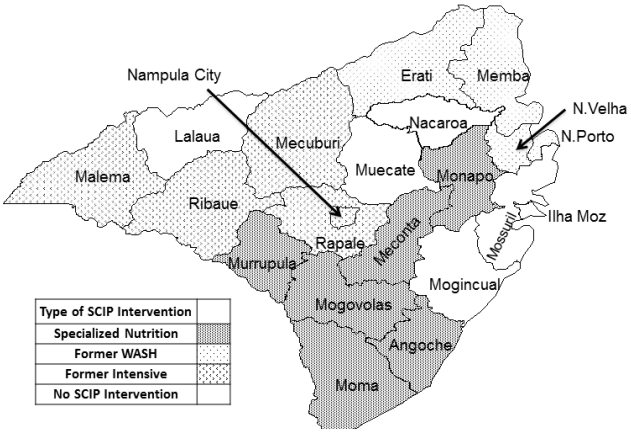
2. DURATION: SIX YEARS & FIVE MONTHS (5 YEARS WITH 17 MONTH EXTENSION)

Life of Project: October 2009 – December 2015

Project Funding: $52,550,000 USD

Geographic focus: 15 districts in Nampula Province - Angoche, Eráti, Malema, Mecubúri, Memba, Mogovolas, Meconta, Monapo, Moma, Murrupula, Nacala Porto, Nacala Velha, Nampula Rapale, Nampula City (two neighborhoods: Namutequeliua and Mutauanha), and Ribáuè compose the current geographic focus of the SCIP project.

FIGURE 1. MAP OF NAMPULA PROVINCE WITH SCIP INTERVENTIONS



3. BACKGROUND

The USAID Strengthening Communities through Integrated Programming (SCIP) Nampula consortium is led by Pathfinder International, in partnership with World Relief (WR), CARE, and the Cooperative League of the USA (CLUSA). The SCIP team focuses on strengthening community systems to bring about behavior change and community services to contribute to better health outcomes, while also addressing social determinants. The overall purpose is to integrate health, water and sanitation, together with nutrition at the community level.

[1] Due to changes in the SCIP Scope of Work during the extension period, Population Services International (PSI) carried out activities through September 2014. From October 2014 through December 2015, the consortium includes Pathfinder, World Relief, CLUSA, and Care International.

For its first four years, SCIP Nampula tailored its package of interventions to meet the varied needs of 14 districts, using a phased approach that targeted some districts with extensive on-going support and others with tapered support as dictated by priority technical areas and the capacity of community structures within each district. In responding to changing programmatic priorities of both the US Government and the Government of the Republic of Mozambique (GRM), SCIP added a 15th district in mid-fiscal year 5 (FY5) and designed enhanced technical assistance aimed at improving malnutrition and strengthening linkages for people living with HIV (PLHIV) to sustained treatment.

The SCIP Nampula project received a 17-month extension from August 2014 to December 2015. In developing the strategic approach for the extension, Pathfinder took into consideration the long-term development goals of the GRM and USAID. The SCIP extension continues to embody Pathfinder's Integrated Systems Strengthening (ISS) Framework, which focuses in the area where community and health systems overlap. SCIP's most important and sustainable achievements take place within this 'zone of interaction' between community systems and health systems, and the project works to strengthen the mechanisms and structures through which actors in both the community and health systems collaborate to develop responses to the challenges that affect both sides of the systems equation. ISS-based activities promote the tangible experience of integration, creating opportunities for community members to participate in the services their local facilities provide, while also expanding the reach of the facilities into the communities themselves. Under SCIP, ISS has assisted both users and providers of health services to understand that sanitation, family planning (FP), maternal and child health (MCH), malaria prevention, immunization, and nutrition are all different faces of the same overarching goal: their health and that of their family. All activities under SCIP are oriented towards a holistic view of health, maximizing integration of service provision wherever possible.

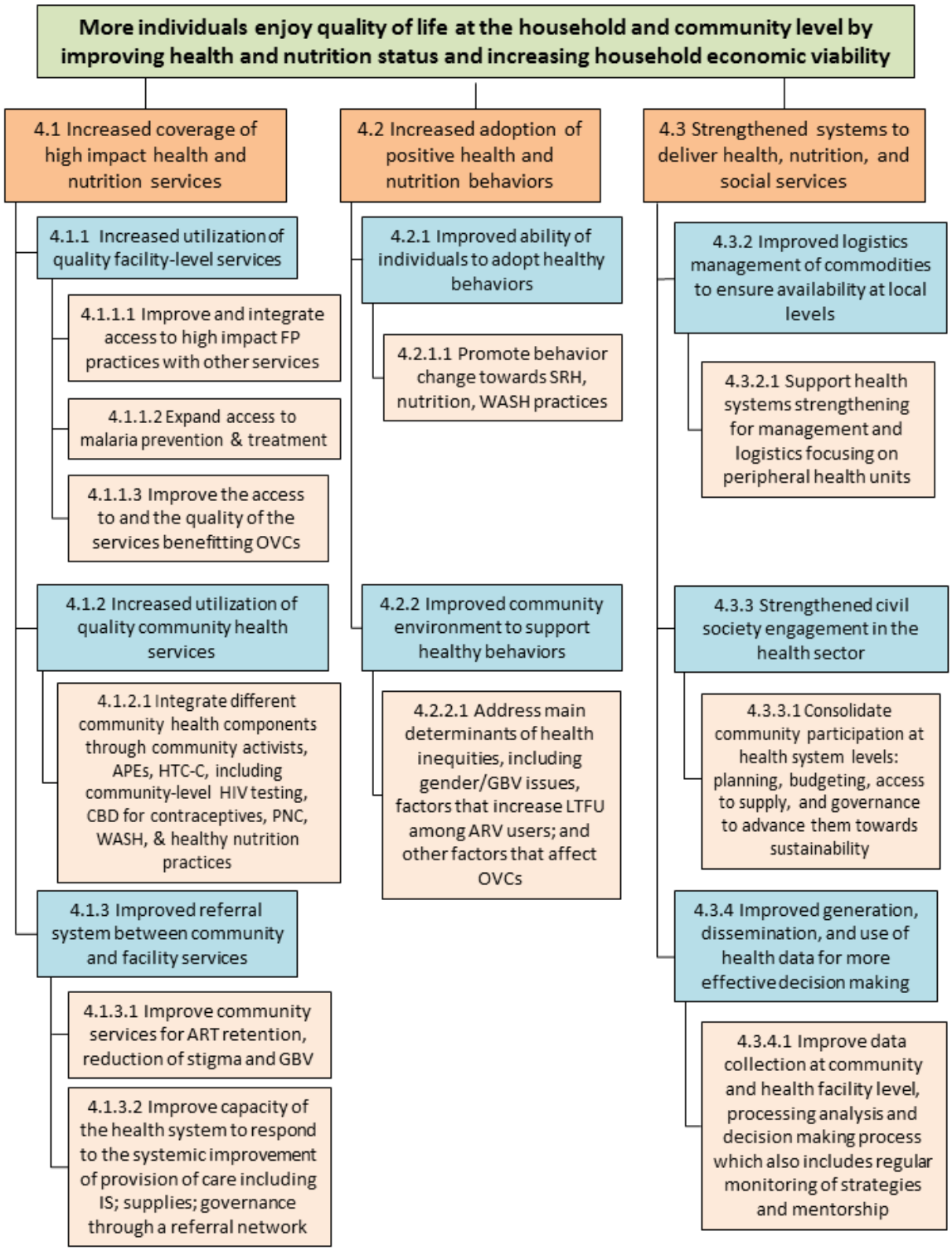
Implementation efforts during this extension center on a more focused and limited set of results and indicators. The SCIP mid-term review represented a valuable and objective assessment of program effectiveness to date, and the resulting recommendations have been adopted for this extension period: (1) maintain the effectiveness of integration as a model for service delivery (capacity-building for assessing community needs, prioritizing activities, and demanding needed services from authorities); (2) establish self-sustainable community structures (devolve more decision-making to the community level, following their lead to more efficiently provide integrated services, and promote opportunities for shared learning between supported community structures), and (3) achieve sustained demand for integrated services (strengthen referral and counter-referral systems to ensure information sharing between community and GRM systems). SCIP continues interventions that have been most successful in building community empowerment, as measured by program results and recommendations made in the review. Other activities are adapted or phased out to reflect current programmatic priorities, resulting in an enhanced vision of SCIP that will facilitate rapid acceleration towards achievement of Development Objective 4 under USAID/Mozambique's Country Development Cooperation Strategy (CDCS): Health Status of Targeted Population Groups improved. For example, building on previous activities of Youth Farmers Clubs, new evidence-based interventions aimed at increasing economic empowerment, such as Village and Savings Loans groups (VSLGs) for Orphans and Vulnerable Children (OVC) and PLHIV are being strengthened.

SCIP has intensified its efforts supporting the achievement of nutrition targets (reducing acute malnutrition rates from 8.0% in 2014 to 1.7% 2015), and improving linkages between communities and facilities aimed at treatment retention for PLHIV. Going forward, SCIP's approach to mitigating undernutrition in the targeted districts will continue its focus on improved community screening and referral for cases of severe acute malnutrition, and consolidate its focus on the development of individualized action plans for families with identified cases of malnutrition. The HIV patient retention activities will continue maximizing the community network (activists and community leaders) to reduce those lost to follow-up (LTFU), while working also to address contributing factors and barriers to retention through behavior change activities.

The SCIP project is supporting efforts to achieve the following results:

- IR 4.1 Increased coverage of high impact health and nutrition services
  - Sub-IR 4.1.1 Increased utilization of quality facility-level services
  - Sub-IR 4.1.2 Increased utilization of quality community health services
  - Sub-IR 4.1.3 Improved active and completed referrals between community and facility services
- IR 4.2 Increased adoption of positive health and nutrition behaviors
  - Sub-IR 4.2.1 Improved ability of individuals to adopt healthy behaviors
  - Sub-IR 4.2.2 Improved community environment to support healthy behaviors
- IR 4.3 Strengthened systems to deliver health, nutrition, and social services
  - Sub-IR 4.3.2 Improved logistics management of commodities to ensure availability at local levels
  - Sub IR 4.3.3 Strengthened civil society engagement in the health sector
  - Sub IR 4.3.4 Improved generation, dissemination, and use of health data for more effective decision making

FIGURE 2. RESULTS FRAMEWORK AUGUST 2014 – DECEMBER 2015



4. MAJOR ACCOMPLISHMENTS FROM THE REPORTING PERIOD

SCIP continued the phase out process through the progressive reduction of technical and logistical support while simultaneously continuing to promote community autonomy in community development. During FY6Q3, activities were phased out in Malema, Ribáuè, Mecubúri, and Rapale, remaining with small teams to support the transition process, and Nampula City concluded activities in FY6Q4. The main activities of phase out include: CLC meetings to evaluate the project, hand over the responsibility of the community network activities to the CLCs, reinforce the linkage between the community and HFs, implementation of HFs' agreement to supply health kits for animadoras, and continuation of OVC sub-committees through linkages with district services. Thirty five (35) supervisors and 240 animadoras were affected by the close-out in these districts.

The impact of this is seen in FY6Q4, particularly affecting the following activities and indicators: # of contacts by CHWs with individuals for health (HIV/AIDS, Malaria, FP/RH), # of OVC served (C.CCC.02.05)R, # of clients receiving Home-based care services (C.CCC.03.03)R, and the # of defaulters searched for/ found/ returned to treatment.

In order to increase government engagement and ownership, as well as sustainability of activities, SCIP invited 463 locality and administrative post chiefs (as well as other relevant government technicians) to a training facilitated by SCIP, SDSMAS & SDPI, and the *Secretarias Distritaís.* This activity consolidated knowledge and skills developed over the past five years working together with SCIP in a broad range of community development topics, and strengthened capacity to monitor and follow up progress achieved in the geographic region for which they are responsible.

In late September 2015, Pathfinder learned that the total estimated fund level was reduced by $600,000 USD. The uncertainty regarding project fund levels and this late notification of SCIP project obligation caused unexpected challenges. Resulting consequences were an impact and slow down regarding the # of people trained with USG funds in: FP/RH, Child health including Nutrition, Maternal/newborn health, M&E, surveillance and/or HMIS, hygiene and water, malaria, community involvement for health and sanitation issues, and roll out of community referral forms requested specifically to be introduced during the cost-extension period.

All project activities in the remaining districts concluded at the end of September 2015, with the exception of the nutrition activities which will be supported up to November 2015 in the six focused districts. The district-level closing out events took place between mid-September and mid October 2015. This was an important event to share the results achieved during the past six years as well as encourage discussion on how to give continuity to activities. All key partners were invited: representatives from all HFs, representatives from all district services, representatives from all localities and administrative posts, representatives from CLCs and the community network, and representatives from other civil society partners. Maps of each administrative post were presented, showing the community platform: CLCs, water committees, agricultural associations and youth farmer clubs, and community health human resources. Achievement in main health indicators were presented by health facility, covering institutional deliveries, FP, HIV prevention, and Nutrition. Attendees were appreciative of the way that

the results were achieved, that implementation was carried out in partnership strongly involving all actors (community, government services, and other local partners).

IR 4.1: INCREASED COVERAGE OF HIGH IMPACT HEALTH AND NUTRITION SERVICES

Total CYP in FY6 was 231,806, 186% of the annual target for FY6, and 146% of the CYP achieved during FY5. This result is testimony to successful system integration between the community and the health system. Coverage of institutional deliveries increased from 77% at the end of FY5 to 85% at the end of FY6. In the same period, the institutional maternal mortality ratio decreased, from 138 to 103 per 100,000 live births.

SCIP has increased the focus on integrating FP within other services, such as the EPI program through mobile brigades and Maternal and Child Health (MCH) weeks, continuing the strategy of providing long-acting methods during these activities, and increasing access of these services to women in the most remote areas. During the past two years, these outreach strategies progressively offered an expanded method mix available to women. Up until July-September 2013, only pills and condoms were offered during outreach activities. Depo-provera was added in October-December 2013, and implants were added in April-Jun 2014. These outreach activities were especially successful due to the demand generated at the community level through community sensitization and mobilization efforts in combination with the capacity-building efforts for providers focusing on counselling and practical skills. Recognizing the link between FP and nutrition, 70% (1,370) of the 1,968 nutrition animadoras have been trained in in FP and CBD. Unfortunately, we were unable to train all animadoras due to restriction of funds.

During FY6, integrated supervision teams of DPS, SDSMAS, and SCIP conducted on-the-job training in Nutrition for 63 providers of 38 HFs in the six Nutrition Districts, assessing existing nutrition skills and capacities. Most of the providers had never been trained in the Nutrition program, and many HFs were missing the needed material and forms in order to report on Nutrition activities. After the technical training, supervision teams, HF staff and the community network meet to discuss acute malnutrition trends as well as follow up activities conducted in the communities. This is an important step to strengthen the link between the community and the HF and to value the community-level contributions to decrease acute malnutrition.

SCIP continues to support HIV treatment retention efforts through the community network of animadoras, HTC-Cs, community leader facilitators (CLF) in the Continuum of Care (CoC) – conducting active searches for defaulting and LTFU patients as well as reducing stigma and discrimination in the community. OF 3,377 patients searched for in FY6, 1,766 were found. 1,110 of those found (62%) were re-integrated to treatment.

IR 4.2: INCREASED ADOPTION OF POSITIVE HEALTH AND NUTRITION BEHAVIORS

Building on the strong community foundation established during the first five years of implementation through CLCs and CLFs in CLTS, Male Involvement, Nutrition and CoC, SCIP has strengthened its focus on regular monitoring and review meetings to encourage community activities and foster accountability.

The work of the CLCs, the CLFs and the animadoras boosts the demand for health services and fosters the adoption of positive health and nutrition behaviors. Achievements resulting from the strong community platform are highlighted through nutrition activities, community-based HIV testing and counselling services for OVPS and integration of OVC families into RSLGs.

SCIP has continued to reduce acute malnutrition rates through FY6. Malnutrition screenings using the MUAC tape and assessment for bilateral edemas take place quarterly, with malnutrition rates continuing to decrease. The acute malnutrition rate of the first MUAC screening in March 2014 was 8.0%, reducing progressively to 1.7% in September 2015. We continue to see high achievement in follow up of malnourished children following their identification during MUAC screenings through household visits, participation in *lareira*, and completed referrals to the HF. In FY6, out of 14,499 cases of acute malnutrition who were followed up at the community level, 87% (12,644) were successfully recuperated at the community level. 2,312 cases were referred to the HF from the community, of whom 85% (1,963) were confirmed as arrived.

Contributing to the Counselling and Testing Objective of the Accelerated Treatment Plan of the MoH, HTC-C counselors tested 30,377 APR individuals for HIV. Of these HIV, OVPs represented 52% (15,912/30,377), including chronically ill individuals and their partners, partners of HIV+ pregnant women, OVCs, truck drivers, migrant populations, and non-injecting drug users. 3.6% of the total (1,091/30,377) were key populations (i.e. sex workers and men who have sex with men (MSM)), and children of OVPs represented 20% (6,221/30,377).

Contributing to PEPFARs economic strengthening strategy for OVCs, SCIP has increased from supporting 143 OVC families (314 OVCs) during FY5Q1 to 2,001 OVC families (3,529 OVCs) in FY6Q2, 2,269 OVC families (4,105 OVCs) in FY6Q3, and 2,418 OVC families (4,393 OVCs) in FY6Q4 benefiting from RSLG activities.

IR 4.3: STRENGTHENED SYSTEMS TO DELIVER HEALTH, NUTRITION AND SOCIAL SERVICES

In FY6, SCIP accelerated activities to support monitoring and evaluation of routine malaria data at district level, in direct collaboration with DPS. Emphasis was directed to improving the collection of malaria data during the quarterly APE meetings, supporting HF supervision, analysis of malaria data during HF Co-Management meetings and monthly SDSMAS health data monitoring meetings with peripheral HFs. The DPS reported improvements in the quality and quantity of data reported by APEs as well at the proportion of districts reporting routine malaria data on time.

Furthermore, SCIP provided technical assistance to HF managers to lead HF CMC meetings and to share HF data with community representatives. Technical assistance was given to the locality chiefs to prepare and implement CLL meetings, analyzing community performance and contributions to achievement of the institutional indicators of SDSMAS, SDPI, and SDETC. At the end of FY6, 97 (out of 139) HF CMCs met during the last quarter.

5. Detailed description of achievements by Result

IR 4.1 Increased coverage of high impact health and nutrition services

Sub-IR 4.1.1 Increased utilization of quality facility-level services

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
1.1 Couple Years Protection (FP)[R]	124,850	186%	69,789	34,902	75,205	51,909
	We achieved 186% of our target for CYP, related to increased FP uptake during the MCH weeks of FY6Q1 & 3.					
1.2 # of facility visits in a health facility, by type	We have significantly exceeded the target for the number of new FP consults. While this indicator is collected in an inconsistent way across providers, the overall trend continues to increase.					
New FP	140,000	276%	137,819	44,451	145,139	59,551
Post-Partum Consult	147,210	133%	47,148	45,612	51,158	51,772
1.3 % institutional deliveries (MCH)[R]	78%	85%	19%	21%	22%	23%
	We have exceeded our target, reaching 85% coverage of institutional deliveries during FY6.					
1.4 # of health staff who received training on counseling and negotiation for nutrition-specific behavior change	46	137%	0	0	50	13
	63 providers received on-the-job training on counseling and negotiation for nutrition-specific behavior change during FY6. More providers were trained per HF due to a higher number of HFs reached than originally planned.					
1.5 % of health facilities in target districts with health staff who received training on counseling and negotiation for nutrition-specific behavior change[R] (N=38 HF)	100%	100%	0	0	87	13
	All 38 Nutrition HFs received training on counseling and negotiation for nutrition-specific behavior change during FY6Q3 & FY6Q4.					
1.6 % of health facilities in target districts - with staff that previously received training on counseling and negotiation for nutrition behavior change - who received nutrition-specific supportive supervision by SCIP staff[R] (N=38 HF)	80%	115%	0	0	0	92%
	35 out of 38 HFs (92%) received nutrition-specific supportive supervision by integrated SCIP-DPS teams, 115% of the target.					
1.7 # of supportive supervision visits for malaria specifically focused on management, MIP, BCC and or/ malaria specific M&E (malaria)[R]	168	52%	27	15	26	19
	There were 87 supportive supervision visits for malaria during FY6.					
1.8 # of M&E reports generated at district and provincial level (malaria)[R]	126	129%	36	36	45	45
	The original target was set by taking 70% of the sum of multiplying 1 report per month by 12 months by 15 districts.					
1.9 # of quarterly planning meetings and	4	1,125%	0	8	20	17

partner meetings held at district and provincial level (malaria)[R]	Planned activities were underestimated, especially at the district level. Number of coordination and planning meetings had to be multiplied in order to improve reporting.					
1.10 # of OVC served (C.CCC.02.05)[R]	30,000	129%	38,625	38,625	38,298	4,393
	We have exceeded our target for this indicator, but the reported numbers of OVCs served decreased during FY6Q4 with the progressive phase out.					
# children who were enrolled in school			1,107	2,026	8	0
# children who received their birth or poverty certificate			1,114	71	0	0
# children referred to the HF			969	825	320	0

SCIP has a number of activities dedicated to increasing the utilization of quality facility-level services, such as family planning (FP), the maternity, at-risk and healthy child consults, and malaria management.

4.1.1.1 IMPROVE AND INTEGRATE ACCESS TO HIGH IMPACT FP AND OTHER HEALTH SERVICE PRACTICES WITH OTHER SERVICES

ANALYSIS OF FP TRENDS THROUGH CYP

As Mozambique is a high HIV prevalence country[2] and the condom (male and female) is recommended for all sexual intercourse, we have presented the quarterly trends of Couple Years Protected by method (without condoms) in the SCIP districts in Nampula Province between October 2010 and September 2015 in Figure 3. We also present an implementation timeline of the different activities contributing to FP uptake in Figure 4. Implementation dates and intensity were derived by triangulating data from project quarterly reports, supervisor and manager reports, and project databases.

CYP (without condoms) has increased from 8,000 CYP in Oct-Dec 2010 to 51,909 CYP in Jul - Sept 2015. Initial SCIP activities for FP started with sensitization activities (addressing the value, barriers, myths, and misconceptions of FP) in the communities through CLC and animadora trainings. The peak in Oct-Dec 2011 is related to including community-based contraceptive pill distribution and improved FP referrals to HFs during the National MCH week. New registration books were introduced in January 2012 and FP activities were poorly captured between Jan-Jun 2012.

SCIP, in collaboration with DPS, has worked intensively to improve provider skills in IUD and implant insertion through practical training and continuous on-the-job supervision. Misconceptions about IUDs were common among providers and needed to be clarified.

Implants started to be offered in May 2012, and IUD insertion has been strongly promoted in the communities and at the HFs, increasing the method mix availability in the province and resulting in increased uptake by women. Note that in the graph, implants are not included until Oct-Dec 2012, as it was not included in the FP consultation register book.

[2] HIV prevalence was estimated to be 10.6% in 2014 by UNAIDS.

However, demand for the implant exceeded availability, especially between April 2013 and March 2014. Depo-provera, contraceptive pills and condoms began to be offered during EPI mobile brigades in Jan-Mar 2013. Approximately 50% of EPI mobile brigades offer FP services for new and existing users as of December 2014. Based on the success of the FP integration with EPI mobile brigades (resulting from Pathfinder advocacy efforts at the National, Provincial and District levels), the Ministry of Health allowed Depo-provera injections to be provided during the National MCH weeks starting in November 2013 and implants in May 2014, significantly increasing the access to these methods for clients living in communities greater than 15 km from the HF. Reflecting on SCIP's achievements, creating an enabling environment at many different levels (community, political, HF) at the beginning was critical to building a foundation receptive to FP and to generate demand.

FY4 and FY5 focused on service delivery strategies to create FP access opportunities for remote populations (greater than three hours by foot), such as integrating FP services in MCH weeks and EPI mobile brigades. Unfortunately, there were not as many decentralized mobile brigades during FY6Q2 as planned, due to the adverse weather conditions of this period. Peaks observed in April-June 2014, October-December 2014, and April-June 2015 coincide with National MCH weeks.

We also assessed annual trends of condoms distributed over a five year period, from FY2 through FY6 (Oct 2010 through Sept 2015), without taking into account the private sector. Nearly 2.5 times as many condoms were distributed in FY6 in comparison to FY2, increasing from 2,367,823 to 5,777,998. 5,777,998 condoms is equivalent to approximately 5.5 condoms per year per woman of reproductive age in the SCIP districts. While this has improved over the course of the project, the number is still low in relation to expectations.

FIGURE 4. TRENDS OF COUPLE YEARS PROTECTED (WITHOUT CONDOMS) PER QUARTER BY METHOD

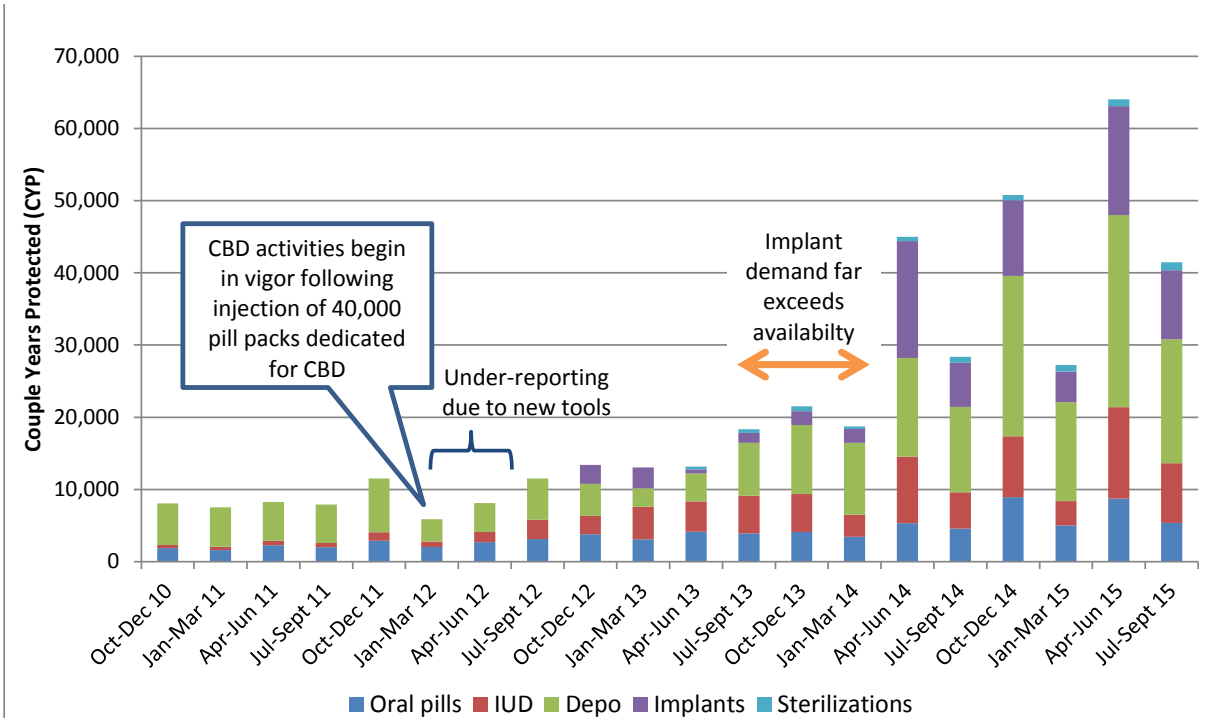


FIGURE 3. TIMELINE OF FAMILY PLANNING INTERVENTIONS

	Family Planning interventions	FY1	FY2				FY3				FY4				FY5				FY6			
		Jul-Sept 10	Oct-Dec 10	Jan-Mar 11	Apr-Jun 11	Jul-Sept 11	Oct-Dec 11	Jan-Mar 12	Apr-Jun 12	Jul-Sept 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sept 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sept 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sept 15
1	CLC sensitization on FP																					
2	Animadoras trained in FP sensitization and CBD of pills, condoms																					
3	Training of CLF in Male Involvement in SRH																					
4	Training of Providers in IUD insertion																					
5	Mentoring of Providers at HFs for FP consultations																					
6	Training of Providers in implant insertion																					
7	Depo, pills & condoms provided in mobile brigades																					
8	Pills and condoms provided in biannual MCH weeks at community level																					
9	Depo provided in biannual MCH weeks at community level																					
10	Implants provided in biannual MCH weeks at community level																					
	Intensity of Intervention (heavy to light)																					

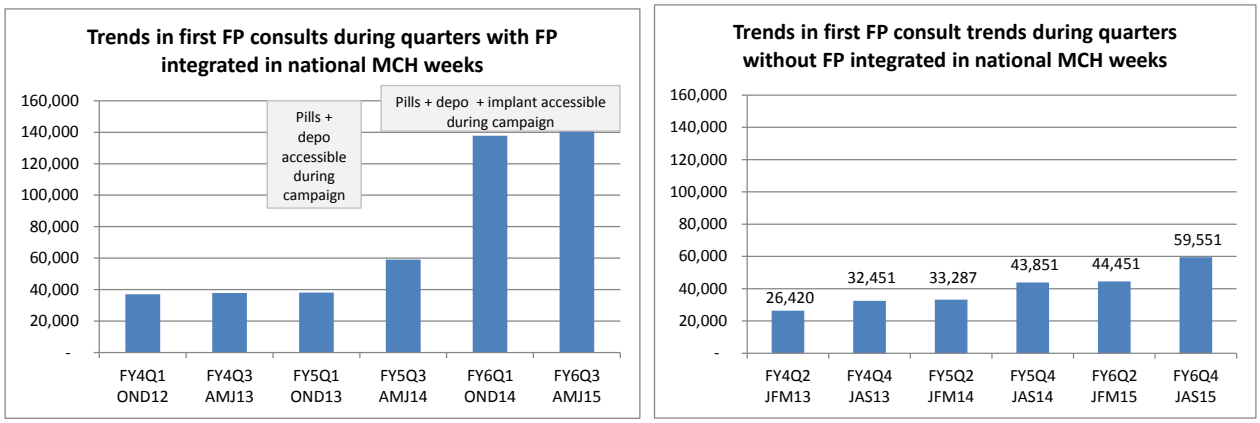
NEW FP CONSULTS

The number of new FP consults is an indicator collected by the MoH at the HF level. There are inconsistencies in the way this number is reported by providers. Some report the first time a client has ever had a FP consult, while others report the first FP consult for a specific method, clients who re-start FP following an extended break, or even clients who have a first FP consult in that particular HF. Despite these weaknesses, as the pool of providers working in the province is mainly the same from one year to the next, the trends in the province can be analyzed to assess the dynamic of FP demand generation and the capacity of the health system to respond to this demand.

During FY6, the quarterly number of new FP consults varied between 44,451 and 137,819. Higher numbers of new FP consults are reported during the quarters in which a national MCH week is held. In order to assess progress on this indicator, we compared the number of new FP consults between quarters during which there is and is not a national MCH week, as shown in Figure 5.

The graph showing the trends of the first FP consults during the quarters with a national MCH week highlight the importance of integrating FP within this activity as it increases the access of users to FP services – especially important in Nampula Province due to the large geographical areas covered per HF - as well as the value of expanding the method mix available. In the second graph, the number of first FP consults during quarters without national MCH weeks increases steadily, demonstrating the improved capacity of HFs to respond to the demand generated at the community level.

FIGURE 5. COMPARISON OF FIRST FP CONSULTS BETWEEN QUARTERS WITH AND WITHOUT FP INTEGRATED IN NATIONAL MCH WEEKS



The revised MCH monitoring tools that will be introduced nationally during November-December 2015 will address the inconsistencies mentioned above by disseminating a standardized definition of the first FP consult and client: the "new FP consult" indicator has been integrated within the more comprehensive "first consult for reproductive health" indicator which includes a variety of services, including FP, but specific to one particular HF. A "new FP user" is defined as "All women who start any modern FP method for the first time in their life".

Training of provincial trainers for the new MCH monitoring tools took place in FY6Q3 with the participation of Nampula, Cabo Delgado, and Niassa provinces. Additional trainings will take place next quarter and the new tools will be introduced at the beginning of 2016.

MENTOR HF PROVIDERS IN THE PROVISION OF FP, MCH, SRH, NUTRITION, AND CHILD HEALTH SERVICES

SCIP continues to increase access to FP and contraception by mentoring providers (during supervision visits) in FP and contraception, SRH, and maternal, neonatal, and child health (MNCH) competencies in alignment with the MOH's quality standards. Provider mentoring is based on quality standards and complemented by on-the-job training to increase practical skills such as IUD and implant insertions, FP counselling and active management of the third stage of labor. Mentoring also focuses on improving the management and flow of MNCH services within each HF. Improving the quality of services provided contributes to improved performance of health indicators. Progress is also assessed during integrated supervision visits with representatives from the Provincial Directorate of Health (DPS) and/or District Services for Health, Women, and Social Welfare (SDSMAS).

In total, 90 of the 120 HFs received at least one mentoring visit during FY6, with visits focusing on the HFs needing the most attention. 41 received at least two visits. Mentoring activities were reduced during FY6 compared to previous years due to a smaller provincial level team. In Eráti, Murrupula, and Nacala Porto, SCIP supported the district MCH supervisors to conduct mentoring and supervision at the HFs.

MCH provincial supervisor mentoring in Rapale.

Apart from evaluating performance standards, SCIP MCH provincial supervisors conduct the following activities during mentoring and supervision visits:

- Support providers in planning and providing health talks addressing FP (including demonstration of the various methods) and prevention of STIs (focusing on double protection);
- Improve hygiene, cleanliness, and organization (prioritizing the maternity, FP, postpartum, and PNC areas);
- Support the FP, postpartum, pre-natal, and child vaccination consults;
- Improve the correct and timely completion of preventive drugs (IPT – "Fansidar", Mebendazol, Cotrimoxazole for HIV+ pregnant women), micronutrients (PP – Vitamin A), and high-energy nutritional supplements (PlumpyNut);
- Assist providers in the accurate and timely completion of consultation register books, community distribution forms, and compilation of statistics;
- Provide technical support for IUD and implant insertion including Tihart compliance;
- Introduce USAID's Environmental Compliance Standards;

- Support timely completion of partograms during delivery, use of the FP eligibility wheel and obstetric calendar, and compliance with humanized delivery standards;
- Support the logistic management of contraceptive stock; and
- Support the meeting with the community network and TBAs.

After the evaluation, the SCIP supervisors and HF team discuss the reasons why certain standards are not met and develop action plans to address these gaps.

In addition to the MCH Quality Standards, attention was given to reinforce seven specific indicators of the Model Maternity Initiative that focus on the humanization of services. These seven indicators are more practical, useful, and accessible than the complete set of MCH Quality Standards and providers are able to calculate their own achievement on a monthly basis.

Humanization of Services Indicators of the Model Maternity Initiative

1. % of women accompanied during the delivery
2. % of deliveries with completed partograms
3. % of deliveries in vertical or semi-vertical position
4. % of deliveries actively managed in the third stage of labor
5. % of women with pre-eclampsia and eclampsia who were treated with magnesium sulfate
6. % of newborns who had immediate skin-to-skin contact with the mother
7. % of newborns who were breast fed in the first hour

Throughout FY6, SCIP supported integrated supervision visits of SDSMAS staff at the HF level in Malema, Memba, Nacala Velha, Moma, Eráti, Rapale, and Monapo. The objective of this activity is to follow and support HF providers in service provision (MCH, EPI, Malaria, Tuberculosis, ART, HF management) and should be done regularly, although some districts have difficulties planning and/or a lack of funding. The visits analyze and revise recommendations from the last visit, compare statistics sent to SDSMAS with the service delivery point, assess patients on ART (including those LTFU), support the FP, maternity, at-risk child consults, intermittent presumptive treatment (malaria prophylaxis), and vaccination services, and functioning of the equipment.

SCIP conducted on-the-job supervision focusing on Nutrition in the 38 HFs located in the specific nutrition community intervention area (covering a general population of approximately 900,000) in the six Nutrition districts during FY6Q3 & 4, with the participation of Nutrition technicians from the District and Provincial Health Directorates and SCIP provincial supervisors. Three visits were planned to each HF, with the following objectives:

1. strengthen the linkage between the community and the HF (including referral-counter-referrals), aiming to reduce the numbers of those LTFU registered in the Outpatient Management of Acute malnutrition program (*Tratamento de Desnutrição em Ambulatório - TDA)*; analyze progress of community-level nutrition activities at the HF level sharing with HFs the data (using charts and tables) from community nutrition rehabilitation in their catchment area.
2. Increase the capacity of providers to identify and treat malnourished children and pregnant women in order to reduce the number of missed opportunities at HF level; and

3. Improve provider skills in correctly completing monitoring forms and register books for the nutritional rehabilitation program (*Programa de Reabilitação Nutricional – PRN*).

Visit #1 served as a baseline to assess basic nutrition skills and capacities of providers. The majority of providers supervised had never received training in the nutritional rehabilitation program or the related forms to complete. During the visit, the teams distributed binders including MUAC tapes, plasticized forms (Child Growth Standards to determine nutritional status, monthly summaries for the nutrition rehabilitation program, the admission criteria for outpatient malnutrition treatment, the prescription guidelines for PlumpyNut), and a folder in which to store community referrals. Most HFs had basic material (CCR register book, stadiometers, scales, and MUAC tapes). A third of HFs visited did not have the PRN register book. The first visit highlighted deficiencies in using the Child Growth Standards to determine nutritional status, and PlumpyNut was not being prescribed as recommended in the Table (weight in relation to the number of days between visits). Two thirds of HFs visited were not familiar with the Community Referral form, which was introduced during FY6Q3. Stock of vitamin A, Mebendazole, vaccines, PlumpyNut, iodized salt tablets was quite good. Capacity at district hospitals is higher than in the peripheral HFs, and there is a lot of variety both between and within districts.

The second and third visits followed up the recommendations left from the first visit. When needed, material was distributed (CCR register books, stadiometers) and providers were trained on their use. At the end of each visit, a meeting was held with the community network and health providers to review the community data from the previous quarter. In general, the situation at the peripheral HFs has improved: missing material was distributed over the course of the visits, and there are less errors in the completion of the PRN register book and monthly summaries of the nutrition rehabilitation form. More providers use the table to prescribe PlumpyNut according to weight of the child. By the second visit, 20 HFs reported making counter-referrals to the community, compared to 11 HFs during the first visit.

While there is progress, quarterly follow up by provincial and district-level nutritionists is recommended to encourage and motivate HF staff, and to follow up on recommendations provided during the on-the-job supervision. In Angoche, the team encountered difficulties in being able to work with the same provider, as nurses were out on holiday, in the district capital for meetings, or otherwise absent. Only a third of HFs met monthly with the community network, a recommendation that will be a real challenge to fulfill following the exit of SCIP support. This experience was important to allow provincial and district nutrition staff to know the realities of the peripheral HFs and to provide supervision.

During the last visit, the supervision team provided training on how to aggregate the community level data at the HF level, for review and analysis at the HF as well as to submit to the district nutrition officer. Of the 38 HFs, 19 had received three visits, 16 had received two visits, and three had received one visit. Additional visits will take place next quarter on an as-needed basis.

63 HF staff received training on counseling and negotiation for nutrition-specific behavior change during FY6. 9 in Angoche, 16 in Meconta, 10 in Mogovolas, 10 in Moma, 15 in Monapo and 3 in Murrupula.

<u>SUPPORT AYRSH SERVICES FOLLOWING HIGH IMPACT PRACTICES AND INTERNATIONAL EVIDENCES OF EFFECTIVENESS</u>

Condom demonstration in a Nampula City Secondary school.

SCIP supported AYSRH services throughout FY6 in ten districts (Eráti, Malema, Meconta, Mecubúri, Memba, Monapo, Nacala Velha, Nampula City, Rapale, and Ribáuè), providing a diverse method mix of contraceptives to adolescents and youth in schools for current and new users. 25 schools held a range of activities, such as health fairs, community theatre, condom distribution, HIV testing, distribution of AYSRH IEC materials, and provider-led health talks in order to promote double protection with condoms, the importance of delaying the first sex, prevention of STI/HIV and unplanned pregnancy, and contraception use.

SCIP supported *Programa Geração Biz* (PGB) planning and coordination meetings in Rapale, Monapo, and Eráti. Schools enjoy receiving visits and invite the providers to come regularly. The PGB committee must work in close collaboration with the schools to improve coordination and reach more schools. The majority of youth request oral contraceptives, but interest is growing in long-acting methods.

SUPPORT JOINT VISITS (SCIP, DPS, ICAP) TO MONITOR HF PROGRESS IN RETENTION EFFORTS

During FY6Q1, meetings were held in Eráti, Angoche, Moma, and Meconta in order to continue improving retention rates of ART clients with the support of the central SCIP and ICAP teams. During these meetings, district SCIP and ICAP teams and ART HF providers discussed retention issues, including how the HF staff is using and can better leverage the community network and how they can strengthen the community-HF link.

During FY6Q2, joint supervision visits (DPS-SCIP) took place in eight SCIP districts (Angoche, Mogovolas, Moma, Rapale, Mecubúri, Ribáuè, Malema, and Murrupula), focusing specifically on HIV program-related indicators: pharmacy, laboratory, HIV, TB, MCH, community linkages, and data. After this visit, improvements were observed in the laboratory (the majority of HFs now provide CD4 and are reporting data on time); the pharmacy (improved register of medications provided to clients as well as what remained in stock). With regards to TB, 70% of individuals who were screened for TB were also tested & counseled for HIV. While cleaning and filing of patient files has improved (an action point which was addressed and supported during previous supervision visits), it remains a challenge.

In FY6Q3, SCIP and the DPS APE manager held a district-level joint supervision visit in Angoche, aiming to improve retention at the peripheral level, maximizing the abilities of APES and their close relationships with chronically ill. No joint visits were held during FY6Q4. Efforts were focused on facilitating the handover of follow up of chronically ill individuals from HTC-Cs to APEs, animadoras, and CoC community leader facilitators, in coordination with each HIV focal point of the HF.

Additional efforts to fortify coordination within the HF are needed to improve retention. The main challenge is in the coordination between services within the HF. For example, a patient has defaulted or

is LTFU on their treatment, yet they still attend other services at the HF, such as pre-natal consults, vaccination services, etc.

INTEGRATION OF FP IN EPI ACTIVITIES

SCIP supported the National MCH week during FY6Q1 & FY6Q3 through the provision of gasoline, transportation, and mobilization of communities through the community network. SCIP also provided technical support through the provincial SCIP MCH supervisors to improve the uptake of FP services offered to clients. These MCH weeks continued providing the implant in addition to offering initial FP consults, follow-up FP consults, distribution of contraceptive pills, Depo Provera injections, and condoms. SCIP further supported a Schistosomiasis mass treatment campaign in Monapo and Nacala Velha during FY6Q1.

SCIP supported a DPS training for 63 providers on the EPI in FY6Q3, and 26 providers in FY6Q4. The training covered consumables management (including vaccines), M&E tools, cold chain maintenance, and the value of including FP in EPI outreach activities (i.e. decentralized mobile brigades).

TABLE 1. NUMBER OF MOBILE BRIGADES SUPPORTED FY6

DISTRICT	Q1	Q2	Q3	Q4
Angoche	14	33	65	51
Nampula City	56	98	115	95
Eráti	108	24	105	71
Malema	21	16	57	53
Meconta	18	16	26	32
Mecubúri	0	24	34	72
Memba	45	47	58	36
Mogovolas	122	46	102	47
Moma	99	2	3	9
Monapo	55	0	74	68
Murrupula	17	31	59	12
Nacala a Velha	8	41	25	37
Nacala Porto	29	30	44	25
Rapale	38	29	31	59
Ribáue	23	0	0	114
Total	**653**	**437**	**798**	**781**

We continue to support decentralized mobile brigades to increase the number of children fully vaccinated. Decentralized mobile brigades are teams of peripheral HF staff that go to remote areas within the catchment area of their HF to provide vaccination services on a regular basis, a SCIP-initiated strategy that began in 2010 in Nampula. Centralized mobile brigade teams are based in the district capital (rather than the peripheral HFs) and provide the same services. FP is integrated within mobile brigades through provision of depo-provera, pills, condoms, and implants (in some of them) as well as initial FP consults, but there remains room for improvement. Approximately 50% of mobile brigades are integrating FP services.

These are our recommendations:

- Reduce the number of registration errors on the child health card. All children should receive the child health card at birth, and it is important to ensure stock of the child health card at the health facility – both in the maternity and during the healthy child consult. HFs should have signs stating that the child health card is provided free of charge, and that it is the right of the child to receive this.
- Improve the planning and implementation of decentralized mobile to ensure adherence to the vaccination schedule. Mobile brigades should visit the same communities every six weeks

throughout the year for children to have enough opportunities to receive all vaccinations prior to their first birthday.

- Data should be collected by concentration point, in the same way that vaccination data is collected at the HF, tracking individual children over time with the vaccinations received.

When comparing the endline survey with the baseline, the percentage of children completely vaccinated by 12 months actually decreased, from 33.5% to 21.1%. This is in contrast with programmatic data of the MOH, reporting between 95-110% coverage for doses administered in the districts.

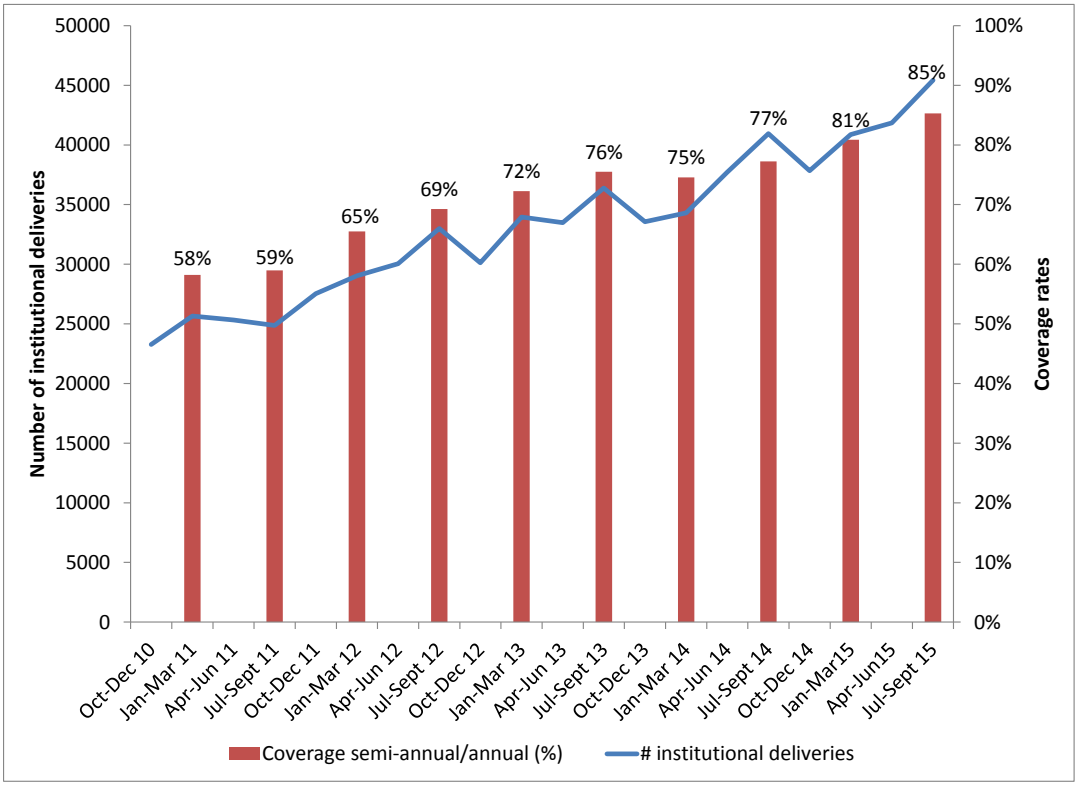
As seen in Table 1, 1,871 mobile brigades were supported throughout FY6 with fuel and per diems. Less decentralized mobile brigades took place during FY6Q2 due to extraordinary weather conditions as described earlier.

During FY6, SCIP continued to implement the "Afternoon of the Woman" activity in Ribáuè, Malema, Monapo, Rapale, and Nampula City. The objective of this activity is to capture additional new FP users in identified communities with low FP adherence. The afternoon begins with introductions to community leadership and a community theatre piece on family planning. Participants are introduced to the different methods of FP and women are able to receive an implant, begin oral contraceptives, or receive injectable contraception. Other services offered include tetanus vaccination, and HIV testing and counseling. Each community is scheduled to receive one visit per month for four months, in accordance with the vaccination schedule. Districts implement the activity according to the realities of their specific needs.

ANALYSIS OF INSTITUTIONAL DELIVERY TRENDS

As presented in Figure 6, 45,427 institutional deliveries were reported in FY6Q4 (compared to 41,853 in FY6Q3, 40,873 in FY6Q2 & 38,419 in FY6Q1). Institutional delivery coverage has increased 9% since the same period one year ago (FY5Q4) and is consistent with trends over the course of the project.

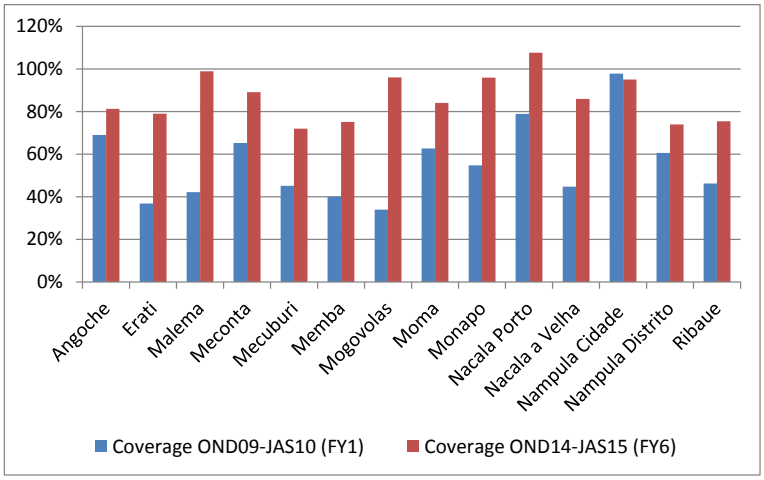
FIGURE 6. SEMI-ANNUAL AND ANNUAL COVERAGE RATES (CUMMULATIVE HF DELIVERIES/ EXPECTED DELIVERIES) AND # OF HF DELIVERIES 15 DISTRICTS - NAMPULA, OCT 10 - JUN 15



SCIP continued providing technical support to CLCs and HF CMCs to reinforce the regular analysis of trends of institutional deliveries. Specific CCIP investments to rehabilitate some maternities, upgrade health posts to health centers (i.e. including a maternity), mentor providers in the humanization and quality of maternity services, provide bicycle ambulances to remote communities, and maternal waiting house construction have likely all contributed to a more comprehensive approach and the increase in institutional delivery coverage.

Figure 7 compares annual institutional delivery coverage from FY1 (OND 2009-JAS 2010) and FY6 (OND14 – JAS15) by district.

FIGURE 7. TRENDS OF INSTITUTIONAL DELIVERY COVERAGE PER DISTRICT, FY1 (OND 2009 – JAS 2010) & FY6 (OND 2014 – JAS 2015)



All districts apart from Nampula City have increased their institutional delivery coverage. Of the two urban districts (Nampula City and Nacala Porto), Nacala Porto has increased its coverage because community empowerment and involvement interventions were concentrated in the surrounding semi-urban areas. Community activities in Nampula City were focused on two (out of the six) neighborhoods and the approach was less comprehensive compared to the other districts. The most rural districts (Eráti, Malema, Mecubúri, Memba, Mogovolas, Nacala Velha) have shown significant improvements, with coverage at least doubling in four of these six districts. In Angoche, no intervention was carried out in the municipality, which alone has a population of 80,000 people. Furthermore, only one third of the localities in Angoche were reached by the community involvement approach.

4.1.1.2 EXPAND ACCESS TO MALARIA PREVENTION AND TREATMENT

The USAID Malaria department requested SCIP dedicate efforts to:

- Support joint provincial supervision (SCIP & DPS) at the district level;
- Support the regular meetings of the provincial level malaria task force;
- Improve the quality of malaria data analyzed at the monthly statistics meeting (at the district level), aiming to decrease the inconsistencies in the reports of the HFs; and
- Support HFs to include the data of the APEs in the monthly report.

In November 2014, SCIP met with national and provincial level staff in order to better define how SCIP can contribute to the improvement of the management of the malaria program implementation. During this meeting, it was agreed that SCIP would carry out specific efforts at the district level through the HF and at community level through the APES to improve the consistency of malaria data collection as well as the quality of malaria services provided.

During FY6, SCIP supported integrated SDSMAS supervision visits for the malaria program (management, malaria during pregnancy, behavior change communication (BCC) and M&E of malaria) in Ribáuè, Nacala Velha, Eráti, and Malema, during which monitoring forms were reviewed and inconsistencies

highlighted, and discrepancies between the number of lab-verified malaria cases and treatment doses leaving the pharmacy were discussed. The technical visit of the Presidential Malaria Initiative of USAID in FY6Q2 helped improve the quality of the technical supervision visits.

SCIP district coordinators and M&E officers also provided technical support to the district malaria focal point. Specific attention was given during the monthly district statistics meetings to analyze aggregated forms of the malaria program. District malaria follow up meetings were carried out in twelve out of fifteen districts, together with the malaria focal point, the SCIP team, and Malaria Consortium staff in order to coordinate community mobilization and mosquito net distribution, building on community structures already supported by SCIP. SCIP supported APE meetings in ten districts (Angoche, Eráti, Malema, Meconta, Memba, Mogovolas, Moma, Monapo, Murrupula, and Nacala Velha) during which participants discussed malaria data as well as supply shortages (rapid tests, medication).

4.1.1.3 IMPROVE ACCESS TO AND THE QUALITY OF THE SERVICES DELIVERED THROUGH SDSMAS, *SERVIÇOS DISTRITAIS DE EDUCAÇÃO, TECNOLOGIA & CULTURA* (SDETC), AND NOTARY SERVICES BENEFITTING OVCS

CONTINUE TO SUPPORT PROVISION OF BASIC PACOV SERVICES BY THE COMMUNITY NETWORK AS WELL AS LINKAGES BETWEEN OVCS AND OTHER PUBLIC SERVICES

The SCIP OVC strategy is based on the National Policy for OVCs (PACOV), which focuses on basic needs and social support. In Y6 of implementation, the community health network continued to support OVC needs in economic empowerment, education, legal protection, referrals for health services as well as psychosocial support, food, and nutrition counselling. These are the basic services that the community network provides on a regular basis. OVCs are identified in a needs assessment during the home visits by the community mobilization network. This same network, in coordination with community leaders and related government institutions, responds to the identified needs.

SCIP has reached 38,625 OVCs in 14 districts with at least one of the seven services during FY6. There are an estimated 200,000 OVCs in Nampula Province. 38,123 OVCs received food and nutrition counselling as well as “Psychosocial, social and/or spiritual support”. 1,296 OVCs were referred from the community to the HF and are reported as receiving the Health Care referral service, and there were 4,393 OVCs whose families were integrated into RSLG and reported as benefiting from the economic strengthening service. Community animadoras use a monthly supervision form for OVCs, which records the type of services provided to each OVC per month.

2,383 OVCs were helped to enroll in school during FY61 & FY6Q2, and subsequently followed up by animadoras and OVC sub-committees in order to encourage the child to remain in school, helping to resolve issues as needed.

SCIP supported 1,180 OVCs through the legal protection service, either through provision of birth certificates or poverty certifications.

The 15 OVCs sponsored by Coca Cola to attend vocational training programs of the National Professional Training Institute graduated in May, completing courses in cooking (2), plumbing (3), and welding (10).

The graduates were supported with the purchase of a professional work kit, internships in local companies, and inclusion in the database of the Nampula Municipality when services are needed. The Nampula Municipal Council will incorporate the follow up of these OVCs within the development initiatives of the Council.

During FY6Q4, SCIP met with the Nampula Municipal Council in order to strengthen the follow up for the 20 OVC families who participate in the economic strengthening activity as Coca Cola venders. As a result, these families have already participated in two capacity-building trainings organized by the municipality.

SUB-IR 4.1.2 INCREASED UTILIZATION OF QUALITY COMMUNITY HEALTH SERVICES

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
2.1 # of communities with access to sanitation (certified with CLTS) (WASH)[R] - Cumulative over the project term	238	86%	169	180	183	204
	We achieved 86% of our target.					
2.2 # people with access to clean water (WASH)[R] cumulative	27,000	159%	7,721	19,294	28,280	42,988
	We have exceeded the target, due to a higher number of rehabilitated boreholes in Moma and Monapo during FY6.					
2.3 # of contraceptive pills distributed through community based distribution (CBD)	78,000	132%	21,513	29,663	26,756	25,319
	During FY6, 103,251 pill packs were distributed through CBD.					
2.4 # of contacts by CHWs with individuals for health (HIV/AIDS, Malaria, FP/RH)	900,000	51%	3,418	185,039	235,642	34,386
	We did not achieve the target as the phase out in the Intensive districts took place sooner than planned due to the reduction and late disbursement of funds. This affected our capacity to collect data from CHWs as animadoras and supervisors were no longer supported by SCIP. In Q1, house visits addressed topics other than HIV/AIDS, Malaria, and FP/RH)					
2.5 % of animadoras in target districts who received training on counseling and negotiation for nutrition-specific behavior change (N: # of animadoras in target districts who received training on counseling and negotiation for nutrition behavior change via project; D: Total # of animadoras to be trained in target districts) cumulative (N4)[R]	100%	97%	86%	95%	95%	95%
	1,931 out of a planned 2,028 animadoras have been trained on counseling and negotiation for nutrition-specific behavior change. Animadora training concluded in FY6Q2.					
2.6 % of animadoras - who previously received training on counseling and negotiation for nutrition-specific behavior change - who received nutrition-specific supportive supervision visit by SCIP staff (N: # of animadoras who received quarterly nutrition-specific supportive	90%	97%	89%	89%	92%	97%
	We have exceeded our target. 1,904 out of 1,968 previously trained animadoras reported data during FY6Q4.					

supervision by SCIP staff; D: Total # of animadoras in target districts who previously received training on counseling and negotiation for nutrition behavior change (N6)	

4.1.2.1 INTEGRATE DIFFERENT COMMUNITY HEALTH COMPONENTS THROUGH COMMUNITY ACTIVISTS, APES, HTC-C, INCLUDING COMMUNITY-LEVEL HIV TESTING, CBD FOR CONTRACEPTIVES, PNC, WASH, AND HEALTHY NUTRITION PRACTICES

TRAIN PROMOTORS, ANIMADORAS AND COMMUNITY LEADER FACILITATORS (CLFS) IN NUTRITION (NUTRITION DISTRICTS)

The SCIP nutrition strategy began in FY5Q2 (January, February, and March 2014), with the objective of reducing severe acute malnutrition in specific localities (covering approximately 50% of the population) in six districts: Angoche, Meconta, Mogovolas, Moma, Monapo, and Murrupula. The community nutrition program contributes to the reduction of acute malnutrition cases in the communities of the targeted areas through theoretical and practical training of community-based promotors, animadoras and community leader facilitators (CLFs). The strategy begins with the recruitment and training of promotors in the nutrition curriculum. The promotors subsequently train two groups of animadoras (10 animadoras per group). Each animadora covers the specific geographic area in which she lives. For improved credibility, support, and sustainability, CLFs are trained alongside the animadoras.

All community-based promotors, animadoras and CLFs were trained in Nutrition as of FY6Q2. At the end of FY6, 115 promotors, 1,986 animadoras, and 1,008 CLFs were active.

	Angoche	Meconta	Mogovolas	Moma	Monapo	Murrupula	Total (active)
Promotors	22	14	19	22	29	9	115
Animadoras	328	281	344	373	480	180	1,986
CLFs	138	139	234	184	250	63	1,008

MATERNAL HEALTH

SCIP has supported various strategies of the MOH focusing on community involvement to improve maternal and sexual and reproductive health outcomes, including bicycle ambulances, maternal waiting houses, training of MCH nurses as facilitators to build CLC capacity, training of animadoras in CBD, and coordination meetings between the community network and the HF.

Ten bicycle ambulances were distributed during FY6, six during FY6Q1 in Malema (CLCs de Tui, Ntacasse, Mueda, Nioce and Pedreira) and Moma (CLC de Cacara), and four during FY6Q3 in Murrupula. CLCs were selected based on their performance in their communities as well as the distance from the HF. Hand over includes meetings with CLCs to discuss the use of the bicycle and bicycle maintenance, and the signing of a Memorandum of Understanding by CLC, locality and HF representatives.

SCIP continues to promote the use of maternal waiting houses (MWH) through the community network. In Angoche the MWH of Namaponda was handed over in FY6Q3. Two MWHs were completed in FY6Q1 in Mogovolas: Nanhupo Rio and Muatua. The MWH of Namitoria (Angoche) is still underway, although severely delayed, and the MWH in Mavuco (under construction by local government with some SCIP support of material) is nearly complete.

COMMUNITY-BASED DISTRIBUTION OF CONTRACEPTION

793 animadoras and 4 promotors (both new and existing) from Angoche, Meconta, Monapo, Mogovolas, and Murrupula were trained to provide contraceptive pills (for existing users) and condoms through community-based distribution in FY6. The training covers counseling on a full range of FP methods to ensure informed choice and compliance with the Tihart amendment. Despite advances made in Nutrition districts, the phase out has had a negative effect on CBD performance in Intensive Districts.

Monthly coordination meetings between the community network and the HF (without SCIP presence) were reported in all districts to encourage sustainability of activities. Meetings during FY6Q4 focused on data analysis, successes and challenges, and phase out of the SCIP project.

FIGURE 8. TRENDS OF CONTRACEPTIVE PILL DISTRIBUTION AND PROPORTION OF PILLS DISTRIBUTED VIA CBD. 15 DISTRICTS IN NAMPULA, OCT 10 – SEPT 15

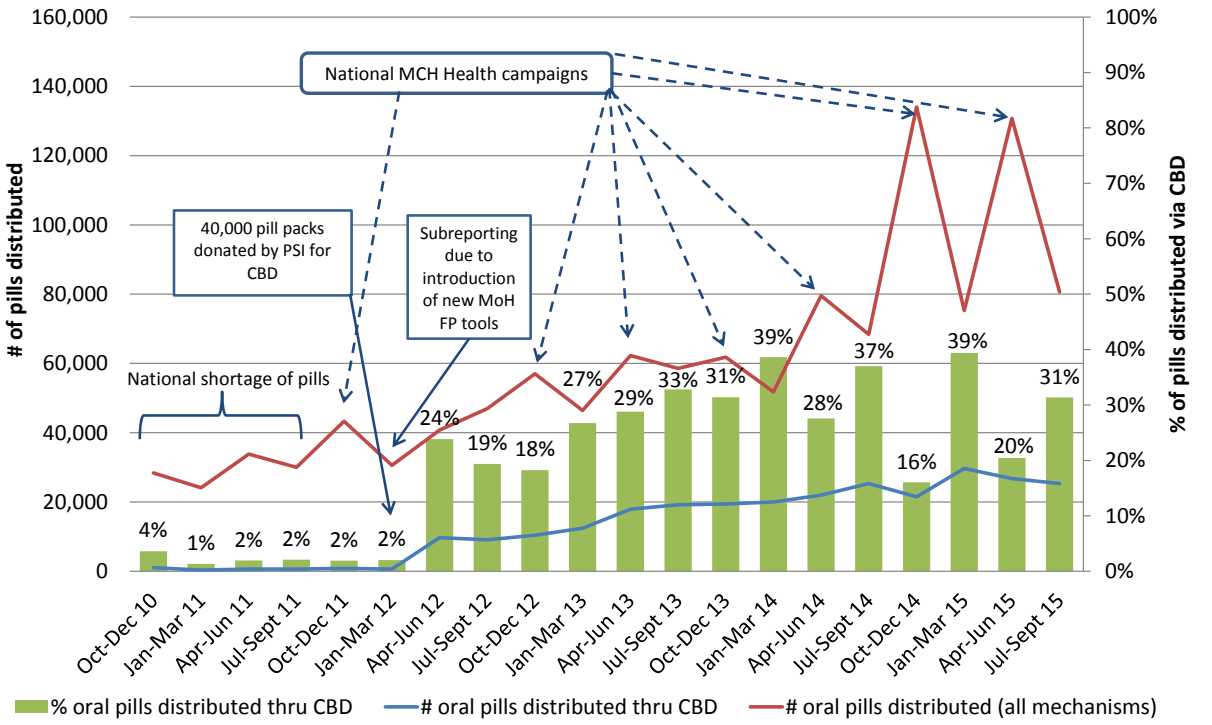


Figure 8 shows the progress made between October 2010 and September 2015 in the number of contraceptive pills distributed and the contribution of CBD activities towards this achievement. During FY6Q4, 31% of the total number of contraceptive pills distributed in SCIP districts were distributed via animadoras. It is important to note that the lower proportion of pills distributed via CBD in Oct-Dec 14 and Apr–Jun 15 (16% and 20%, respectively, of all oral pills distributed were distributed thru CBD) is due to the higher overall number of oral pills distributed during the MCH week, during which three pill packs were given to continuing contraceptive pill users, and one pill pack was given to new users.

WASH

During FY6, WASH activities were primarily conducted in Nutrition localities, employing the Community-led Total Sanitation (CLTS) approach. Trained CLs facilitate the process in their communities and are responsible for monitoring and collecting information on the number of latrines constructed in determined periods, as well as reporting the successes and challenges of their communities. Once there is 100% latrine coverage in their communities, CLs invite the assessment team to be evaluated as "Open Defecation Free" (ODF). The evaluation is conducted by a multidisciplinary team of government officials from the Provincial Directorates of Public Works, Education and Culture, Health, the Environment and other District Government officials, as well as project technicians and other interested parties.

235communities were certified as ODF in FY6. Table 2 shows the distribution of ODF communities since 2011. 43 CLTS CLFs were trained during the year, as the majority had been trained at the end of FY5.

Meetings of CLTS CLFs are held at the locality level in order to encourage appropriation of monitoring activities by the locality chief. This activity was reinforced during the locality chief training and during closing ceremonies at the district level.

TABLE 2. NUMBER OF COMMUNITIES DECLARED ODF

	2011	2012	2013	2014/ 2015	Total
Angoche	-	-	-	3	3
Eráti	7	14	25	11	57
Memba	-	12	36	8*	56
Mogovolas	-	-	-	5	5
Monapo	5	8	23	11	47
Nacala Porto	-	1	4	-	5
Nacala Velha	-	14	10	7*	31
Total	12	49	98	45	204
(*) Communities declared ODF not reported in previous years					

The mapping exercise was useful to have a picture of the current CLTS strategy implementation in the six districts. 544 active CLCs were mapped and surveyed, of which 410 reported having at least one CLTS CLF. 574 community leaders were trained as CLTS facilitators by SCIP project staff over the life of the project. In some districts (Angoche, Murrupula), partnerships between neighboring CLCs allowed additional CLTS CLFs to be trained, a concrete example of community empowerment and the community training cascade. In other districts, more than one CLF per CLC was trained directly by project staff, related to the geographic size of the CLC, political affiliations, and local CLCs dynamics.

Preliminary results of the EAWAG study conducted during FY6Q3 highlighted that construction of latrines is perceived as a man's job, as is the decision of whether or not to construct a latrine. Consequently, female headed households are less likely to have a latrine. CLTS meetings and trainings are also perceived by the community to be a male domain. Future projects should take this gender imbalance into consideration when developing CLTS activities.

SCIP met 81% of the target number of communities to be declared ODF. The extreme rainy season (between January and March 2015) and floods destroyed existing latrines, as well as slowed down latrine (re)construction. It took time to mobilize communities to reconstruct. Communities rely on local material for latrine construction which is more available during the dry season.

TABLE 3. WATER COMMITTEES TRAINED IN NUTRITION DISTRICTS

	# Water committees trained						
District	**FY5Q3**	**FY5Q4**	**FY6Q1**	**FY6Q2**	**FY6Q3**	**FY6Q4**	**Total**
Angoche	9	6	0	0	3	1	19
Meconta	6	6	0	2	3	1	18
Mogovolas	8	7	0	0	2	4	21
Moma	8	19	0	5	6	0	38
Monapo	3	11	16	10	0	0	40
Murrupula	0	7	0	9	0	0	16
TOTAL	**34**	**56**	**16**	**26**	**14**	**6**	**152**

Water committees are first trained on water source management and subsequently on operation, maintenance, and repair of water pumps. Water committees are shown how to use excess water in the pump area to grow vegetables and how to use local materials to build fences to keep out animals. These committees are responsible for reporting diarrhea outbreaks to

HFs. Water committee members also participate in the HF CMCs, support talks on health days and actively participate in mobile brigades. Committee activities (meeting minutes, contributions, expenses for spare parts and accounting) are recorded in the maintenance book. In FY6, 62 water committees were revitalized in the six Nutrition Districts, as demonstrated in Table 3. A lot of effort was made to train water committees, much beyond the number of water pumps planned for repair: since the second semester of FY5, 152 water committees were trained, in relation to 58 repaired water pumps. This was necessary due to the number of functioning water sources identified without operational water committees (i.e. no maintenance/management book in use, no regular maintenance performed, and no contributions being made/recorded).

TABLE 4. NUMBER OF REPAIRED WATER SOURCES

District	FY6Q1	FY6Q2	FY6Q3	FY6Q4
Angoche	**0**	**0**	**4**	**4**
Meconta	**0**	**2**	**0**	**2**
Mogovolas	**1**	**1**	**4**	**0**
Moma	**6**	**4**	**10**	**0**
Monapo	**0**	**2**	**2**	**5**
Murrupula	**0**	**3**	**0**	**0**
Total	**7**	**12**	**20**	**11**

SCIP repaired 50 of the planned 52 water pumps in the Mogovolas, Angoche, Moma, Meconta, Monapo, and Murrupula districts in FY6, the distribution of which is illustrated in Table 4.

Eleven water sources in Angoche and Moma that were damaged as a result of the flooding of FY6Q2 were repaired during the last semester of FY6.

Inauguration ceremony brochure for the small water system of Nacala Porto.

Apart from water pump repair, SCIP completed the construction and handed over a small water system in Nacala Porto during FY6, benefiting 6,500 individuals from the communities of Mahelene, Lili, and Chalaua. This was a challenging undertaking, which relied on initial surveying done by foot through the bush and the construction and opening of roads to allow pipes to be laid for water reticulation. SCIP partner, CARE, facilitated the process using exclusively local labor and artisans and in partnership with SDPI and EDM. The system includes 15km of underground piping, and has 30,000 liters of storage capacity and 30,000 liters/hour pumping capacity.

SUB-IR 4.1.3 IMPROVED ACTIVE AND COMPLETED REFERRALS BETWEEN COMMUNITY AND FACILITY SERVICES

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
3.2 # of defaulters searched for (Active Finding Pilot Indicator)[R]	3,300	102%	971	1,070	840	496
	3,377 defaulters were searched for during FY6, 102% of the annual target.					
3.3 # of defaulters found (Active Finding Pilot Indicator)[R]	2,200	81%	505	431	581	272
	1,789 defaulters were found, 81% of the target of 2,200. It was more difficult than expected to find the individuals on the active search lists provided by the HFs.					
3.4 % of defaulters returning to treatment (Active Finding Pilot Indicator)[R]	65%	62%	60%	66%	55%	75%
	1,110 out of 1,789 defaulters returned to treatment. 38% of those found refused to return to treatment. Further reflection should analyze the barriers defaulters have to return to treatment.					
3.5 # of clients receiving Home-based care services (C.CCC.03.03)R	6,200	121%	6,968	7,522	7,406	5,256
	7,522 individuals received HBC services during FY6. This number reduced to 5,256 in FY6Q4, following the exit of animadoras in intensive districts.					
3.6 # of people trained with USG funds in: FP/RH, Child health including Nutrition, Maternal/newborn health, M&E, surveillance and/or HMIS, hygiene and water, malaria, community involvement for health and sanitation issues	92,000	72%	19,127	30,227	13,899	2,554
	65,807 people were trained with USG funds during FY6. We did not achieve our annual target due to uncertainty and reduction of funds.					
3.7 # of community health and para-social workers who successfully completed a pre-service training program (SS. HRH.02.06)[R]	150	79%	81	0	37	0
	37 animadoras from Nampula City were trained to lead small groups of adolescent girls between 10-14 years on HIV prevention including FP. We reached 79% of our target. We did not achieve our annual target due to uncertainty and reduction of funds.					
3.8 # of people referred to health facility for Family Planning (FP)[R]	70,000	16%	514	3,616	727	1,737
	Referrals of 11,234 individuals who were referred to the HF for FP were reported in FY6. There is a lot of under-reporting. Indeed, CYP (1.1) and the number of first FP consults (1.2) have surpassed the target.					
3.9 #/% of completed health referrals for FP services (FP)[R]	42,000	1%	-	-	155/21%	94/5%
	Follow up of this activity (M&E, information flow, follow up) never fully matured but the number of non-registered referrals is increasing, evidenced by the results of 1.1 and 1.2.					

*** A patient on pre-ART treatment is considered "late" when they do not appear between 6-6.5 months after their CD4 count, a "defaulter" when they do not appear between 6.5 and 8 months after their CD4 count, and "LTFU" when they do not appear at the HF for 8 months or longer after their CD4 count. A patient on ART is considered "late" when up to 2 weeks pass before picking up their medication, a "defaulter" if 2 weeks to 2 months pass without picking up their medications, "LTFU" when more than 2 months have passed without picking up their medication. (PEPFAR Mozambique April 2013)*

4.1.3.1 IMPROVE COMMUNITY SERVICES FOR ART RETENTION, REDUCTION OF STIGMA & GBV

TRAINING OF APES, CLFS, HTC-CS IN CONTINUUM OF CARE AND PREVENTION WITH POSITIVES

SCIP has invested in the training of APEs, CLFs, HTC-Cs, and Animadoras in the Continuum of Care curriculum (including prevention with positives) as a community-level approach to improve retention of HIV+ individuals to ART services. When needed, refreshment activities are held with previously-trained community members to refine skills and provide technical updates, as well as to motivate and encourage Continuum of Care activities at the community level. During refreshment activities, participants review the reporting system, the referral and counter referral process with the HF, and how to improve active search outcomes.

In FY6Q1, we completed the initial CoC training with 34 APEs from Murrupula and 47 substitute animadoras in former Intensive districts, and 99 APEs participated in refreshment activities from Mogovolas, Moma and Angoche.

FOLLOW UP OF PRE-ART AND ART PATIENTS, ACTIVE SEARCH OF DEFAULTERS AND LTFU

In order to increase adherence to treatment, community network supervisors, HTC-Cs, and APEs retrieve lists of late/defaulters/LTFU chronically ill patients from ART HFs so they can encourage them to return to the HF for treatment. Animadoras are especially important in this process as they are in regular contact with chronically ill patients and their families. Table 5 details the distribution of the different HBC/PwP providers as well as their implementation strategy.

TABLE 5. DISTRIBUTION OF PWP/HBC PROVIDERS AND APPROACH BY TYPE AS OF FY6Q4

	Districts	# of PwP/HBC community providers	Observations
APEs	Moma (52), Meconta (32), Mogovolas (42), Monapo (30), Angoche (52), Eráti (50), Murrupula (34), Memba (24), Nacala Velha (22)	338	• Fixed, village-limited geographical area • Integrated health approach • All chronic diseases as defined by the MoH
Animadoras	Ribáuè (43), Rapale (41), Nampula City (42), Malema (44), Mecubúri (70)	240	• Fixed, village-limited geographical area • Integrated health approach • All chronic diseases as defined by the MoH • Ribáuè, Rapale, Malema, Mecubúri supported by SCIP until April 2015 • Linkages between the animadoras and the HF were strengthened prior to phase-out.
HTC-C	Moma, Meconta, Mogovolas, Monapo, Ribáuè, Rapale, Nampula City, Malema, Mecubúri, Memba, Nacala Porto, Nacala Velha, Eráti, Angoche	20	• Mobile, within 2-3 localities • Follows up only HIV+ patients • Will discharge HIV+ patients to APEs / animadoras where existing • Support APE & Animadoras for community-based HIV testing of higher risk groups • Supported by SCIP through September 2015

As part of the phase-out process, the team of HTC-Cs reduced by 10 (from 30 to 20) during FY6. The chronically ill individuals of these HTC-Cs were transferred to the APEs and CoC CLFs in the respective areas. The SCIP team developed a programmatic database to help track chronically ill patients and facilitate the transition of the chronically ill patients, using the data collected in the *Livro de Seguimento de Doentes Crónicos*. This allows for the assessment of the quality of services provided and the progress made in achieving behavior change objectives in relation to Services 1 (condom use) and 2 (sharing sero-status with partner, HTC with partner).

As part of the progressive SCIP phase out, 200 animadoras from Ribáuè, Malema, Rapale, and Mecubúri received their last subsidy in April 2015, and the remaining animadoras from Nampula City received their last subsidy in September 2015.

In FY6, 3,377 clients (defaulters/LTFU) were searched for, of which 1,766 (52%) were found alive. Of those found, 1,110 (63%) were re-integrated to treatment. In addition, 137 (8%) of those searched for were confirmed by the community network as passed away. Of these, 21 were defaulters and 116 were LTFU. A higher proportion of defaulters, and a lower proportion of LTFU were found in FY6Q4 in comparison to previous quarters. A higher percentage of those found were reintegrated to treatment, a trend that has been improving over FY6. That said, the absolute numbers reported during FY6Q4 were lower, due to the reduction of animadoras in Intensive Districts and the loss of six HTC-Cs.

	FY6Q1 OND14		FY6Q2 JFM15		FY6Q3 AMJ15		FY6Q4 JAS15	
	DEF	LTFU	DEF	LTFU	DEF	LTFU	DEF	LTFU
# searched for	243	728	152	918	229	605	80	416
# found (%)	138 (57%)	367 (50%)	95 (63%)	336 (37%)	157 (69%)	424 (70%)	68 (85%)	201 (48%)
# reintegrated to treatment (%)	108 (78%)	194 (53%)	86 (91%)	197 (59%)	131 (83%)	190 (45%)	61 (90%)	143 (71%)

The community network is more successful in locating defaulters and in re-integrating them to treatment than those LTFU. LTFU clients are especially challenging to reintegrate to treatment: they have not picked up their medication for over two months and there is little information available as to why – the client may have moved, may be bed-ridden, may not have responded well to the treatment, or may have passed away. It continues to be critical that HFs correctly manage their patient files to be able to report non-adherent patients when they are in the defaulter stage rather than LTFU. In the 55 HFs fully supported by ICAP, we can see a difference in the ART services provided. The main task of ICAP is to organize the files of the patients.

Figures 9 and 10 illustrate the performance by district over FY6.

FIGURE 9. DEFAULTERS SEARCHED FOR, FOUND, & RETURNED TO TREATMENT – OND14, JFM15, AMJ15, JAS15

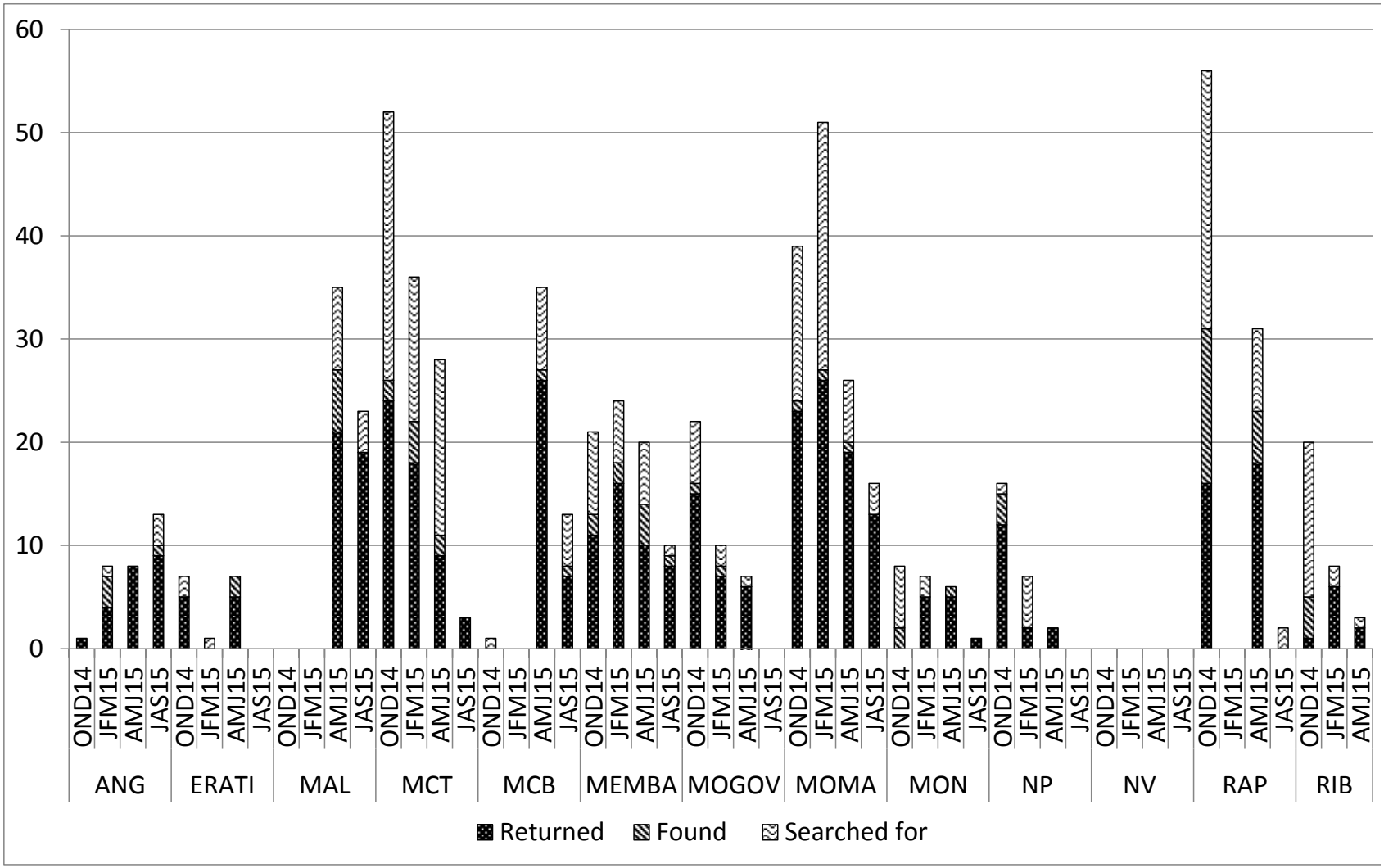
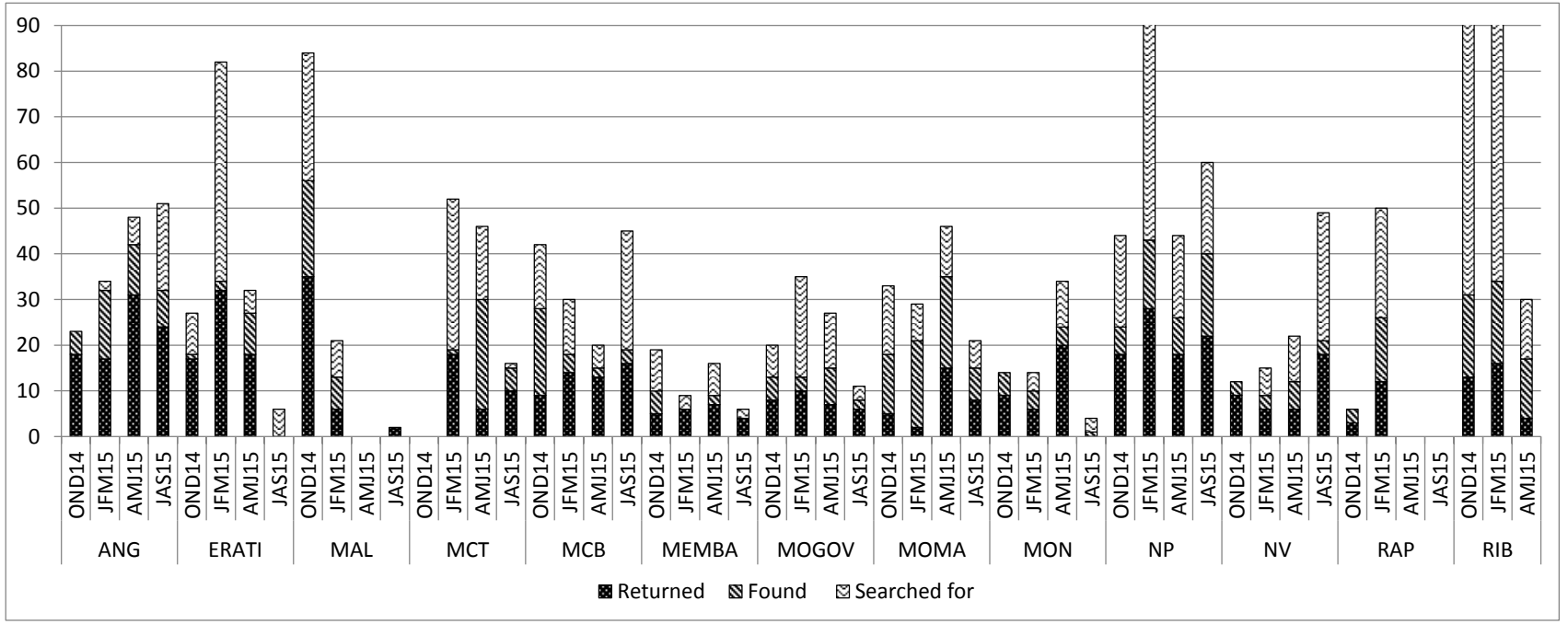


FIGURE 10. LTFU SEARCHED FOR, FOUND, & RETURNED TO TREATMENT – BY QUARTER FY6



In general, the numbers of defaulters searched for in the districts are decreasing over the course of FY6, and there is improvement in the proportion of defaulters reintegrated to treatment.

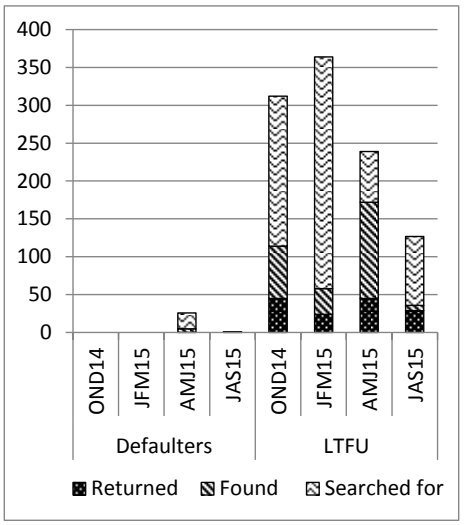
- While Nacala Velha does not report defaulters, they do report those LTFU and they have increased both the number searched for and the number returned to treatment over FY6, a good indication of stronger community-HF linkages but a less effective program at the HF level as the number of LTFU is increasing.
- Malema, Meconta, Memba, Moma, and Mogovolas have reported decreasing numbers of defaulters and LTFU over time, suggesting they have stronger implementation of the HIV program at the HF level and efficient linkages with the community network. These districts also reintegrate the majority of defaulters found.
- Weaknesses persist in Angoche, Mecubúri, Nacala Porto, and Nacala Velha, as trends of LTFU searched for are increasing. In Angoche, defaulters searched for are also increasing.

Nampula City continues to have difficulties in providing lists of defaulters. There are delays in updating the database. Clients are also reluctant to provide accurate information for them to be located in the event they default on treatment.

As seen in Figure 11, the number of LTFU searched for has decreased over FY6. This could be indicative of an increase in the quality of care at the HF level. Meanwhile, the proportion of those found out of those searched for remains low, revealing the low coverage of community activists involved in active search activities.

Five of the ten HFs in Nampula City report data. During FY6, 1,069 defaulters and LTFU were searched for, of whom 386 were found. 144 of these were re-integrated to treatment.

FIGURE 11. DEFAULTERS AND LTFU SEARCHED FOR, FOUND AND RETURNED IN NAMPULA CITY – OND14, JFM15, AMJ15, JAS15



4.1.3.2 IMPROVE CAPACITY OF THE HEALTH SYSTEM TO RESPOND TO THE SYSTEMIC IMPROVEMENT OF PROVISION OF CARE INCLUDING IS; SUPPLIES; GOVERNANCE THROUGH A REFERRAL NETWORK

STRENGTHEN THE REFERRAL/COUNTER-REFERRAL SYSTEM FOR CHILD-AT-RISK CONSULTS

Specific on-the-job training was provided to health providers from 38 HFs in the six Nutrition Districts during the second half of FY6 in order to strengthen to the referral/counter-referral system for at-risk child consults. While the community network has been making referrals for at-risk children since April 2014, the community referral book was only introduced in May 2015. Two-thirds of the HF staff were familiar with and used the form. Half reported making counter-referrals from the HF back to the community. Material was provided during the visits in which to store the referrals and orientation given to Promotors /Providers on how to use the form at the HF and community level as well as reporting expectations.

In FY6, 1,537 out of 1,806 (85%) severe acute malnutrition cases identified at the community level through MUAC who were referred to the HF were confirmed as arrived.

99 out of 107 (93%) of severe acute malnutrition cases identified at the community level through identification of bilateral edemas were confirmed as arrived.

See Section 4.1.1.1 for more details.

Community referrals received at the HF.

STRENGTHEN THE REFERRAL/COUNTER-REFERRAL PROCESS FOR ART/PRE-ART CLIENTS

Efforts during FY6 focused on strengthening the relationship between the community network and the HF, aiming for a productive referral/counter-referral process. HTC-Cs and district supervisors participate in various HF meetings (weekly ART meeting, weekly clinic management meetings, quarterly ART committee meetings) during which accounts are given for active search activities. ICAP supports either directly or indirectly the clinical HIV services in all 72 ART HFs. Technical meetings between SCIP, ICAP, and providers have been important to define information flow and encourage regular updating of defaulter/LFTU lists.

Along with the HF HIV treatment managers, provincial SCIP supervisors met with the district teams in order to standardize the counter-referral collection process from HFs. These counter-referrals are important as they serve as confirmation that the person referred from the community arrived. While there is progress, much more effort (on the part of health staff and SCIP) is needed to strengthen this referral-counter referral process.

IR 4.2 INCREASED ADOPTION OF POSITIVE HEALTH AND NUTRITION BEHAVIORS

SUB-IR 4.2.1 IMPROVED ABILITY OF INDIVIDUALS TO ADOPT HEALTHY BEHAVIORS

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
4.1 # of individuals who received Counseling and Testing (C&T) services for HIV and received their test results - by CT Type: ATS-C (P.CT. ATSC.01.03)[R]	26,600	114%	6,392	9,455	8,434	6,096
	We have exceeded our target, and have succeeded to focus on OVPs, who represent 52% of the total 30,377 tested, key populations (3.6%), and children of OVPs (20%).					
4.2 # of priority populations reached with preventive interventions (single and multiple sessions) (P.SBRP.07/08)[R]	29,720	52%	3,357	4,910	4,576	2,586
	The target has shifted from 180,000 to 29,720 due to changes in indicator definition per APR14 recommendation. Sensitization of HIV prevention for the general population (P.SBRP.01) is no longer recommended to be reported for APR15 and was replaced by P.SBRP.07/08 (Number of priority populations reached). Planned activities were cancelled as PEPFAR funds were re-oriented for more treatment and less prevention.					
4.3 # Key Populations (MARP) individuals reached with preventive interventions (P.SBRP.03.03)[R]	2,000	-	-	-	-	
	No longer applicable due to changes in indicator definition per APR14 recommendation.					
4.4 # mass media spots & events produced (P.SBRP.04.05)[R]	33,500	98%	31,657	1,087	950	638
	3,253 radio spots were broadcast and 379 community theatre pieces were performed during FY6. 20,700 "Modern Methods of FP" and 10,000 "7 reasons to use a condom" were distributed during FY6Q1.					
4.5 # targeted condom service outlets (P.SBRP.05.01)[R]	1,692	142%	2,186	2,403	2,339	2,336
	We have trained animadoras from Nutrition districts to provide CBD of contraceptive pills and condoms, which was not originally included in this target.					
4.6 # of children measured using MUAC tool at the community level (N1)[R]	140,000	110%	107,163	147,229	150,825	153,502
	We have exceeded our target, likely due to underestimations of population size.					
4.7 % of children measured with acute malnutrition via MUAC (N1a)[R] (N: # of children measured with acute malnutrition via MUAC; D: All children measured via MUAC)	1.5%	0.1%	0.6%	0.4%	0.2%	0.1%
	We have exceeded our target, based on the strong community interventions for nutrition. 219 children out of 153,502 children screened in FY6Q4 were severely acutely malnourished (via MUAC).					
4.8 % of children measured with acute malnutrition (via MUAC) who were referred for clinical care (N2)[R] (N: # of children measured with acute malnutrition (via MUAC) referred for	100%	86%	91%	68%	106%	84%
	1,806 out of 2,097 (86%) children were referred for clinical care during FY6.					

clinical care; D: All children with acute malnutrition (via MUAC))						
4.9 % of children measured with acute malnutrition (via presence of bilateral pitting edema) who were referred for clinical care (N2a)[R] (N: # of children measured with acute malnutrition (via bilateral edemas) referred for clinical care; D: All children measured with acute malnutrition(via bilateral edemas))	100%	81%	75%	79%	119%	59%
	216 out of 267 children (81%) identified with bilateral edemas were referred for clinical care.					
4.10 % of children measured found with acute malnutrition (via MUAC) with completed referrals to clinical care (N2b)[R] (N: # of completed referrals for acute malnutrition made via MUAC; D: # of referrals made for acute malnutrition (via MUAC)	80%	85%	88%	83%	85%	84%
	During FY6, 1,537 out of 1,806 (85%) children with acute malnutrition (via MUAC) who were referred to treatment completed their referral.					
4.11 % of children measured found with acute malnutrition (via presence of bilateral pitting edema) with completed referrals to clinical care (N2c)[R] (N: # of completed referrals made for acute malnutrition (via bilateral pitting edema) : # of referrals made for acute malnutrition (via bilateral pitting edema)	80%	93%	93%	91%	97%	90%
	In FY6, 99 out of 107 children (93%) with bilateral edemas who were referred for treatment were confirmed as completed.					

4.2.1.1 PROMOTE BEHAVIOR CHANGE TOWARDS SRH, NUTRITION, WASH PRACTICES

PROMOTE BEHAVIOR CHANGE THROUGH CLCS, CLFS

SCIP continued to support Hot Topics discussions in Sexual and Reproductive Health in the communities. Facilitated by trained health providers during five afternoons in each of the HFs catchment areas, these activities have occurred in all the districts. Trained community leaders subsequently facilitate discussions in their communities to discuss these issues and address concerns about the services provided at the HF, especially FP.

In FY6, 795 CLs from Mecubúri and Murrupula participated in Hot Topics discussions.

SCIP continued with the strategy of training community leaders as facilitators (CLFs) in different health topics, during FY6 focusing on Male Involvement in SRH (167 CLFs trained from Memba, Moma, Murrupula, Rapale, and Mogovolas), CLTS (189 CLFs trained from Monapo, Eráti, and Nampula City), and Nutrition (215 CLFs trained from Angoche, Mogovolas, Monapo, Moma). These CLFs serve as focal points in their community for the specific theme – Nutrition CLFs, for example, have a key role in mobilizing community women to bring their child to participate in the quarterly screenings for acute malnutrition.

Districts report that the training of CLs as facilitators has been important in enabling a positive environment at the community level for adoption of positive behavior change. CLs have gained confidence with their increased knowledge of health and nutrition issues and feel more empowered to interact with health providers. During HF CMC meetings, CLs discuss reports received from community members of perceived poor treatment by providers. In Angoche, community leaders participate as observers when HFs receive medication kits, verifying the quantities received as they are stocked in the pharmacy.

CLTS CLFs are recording the numbers of latrines constructed in their communities each quarter, identifying the households that have not yet built a latrine and discussing strategies to overcome barriers for these households.

PROMOTE BEHAVIOR CHANGE THROUGH COMMUNITY RADIO, COMMUNITY THEATRE GROUPS

During FY6, SCIP continued to work with community radio stations to share information on FP & MCH, HIV, malaria, conservation agriculture, nutrition, and diarrhea prevention. The radio stations broadcast spots (in Portuguese and eMakhuwa), host live radio discussions held in the communities, and broadcast interviews and testimonials. SCIP district teams and the community radio stations meet monthly to share information on community activities, agree on a broadcasting schedule for radio spots and to organize for on-air discussions and interviews.

49 new radio spots were produced (23 in Portuguese and 26 in eMakhuwa) during FY6Q1 addressing Hygiene and Sanitation, Conservation Agriculture, Malaria, and Maternal and Child Health.

Over the course of the year, the number of radio stations with whom SCIP had MoUs decreased from eleven (Nacala Porto (Rádio Watana & Rádio Comunitária), Monapo (Centro Multimédia Comunitário), Meconta (Rádio e Televisão Comunitária), Memba (Rádio e Televisão Comunitária), Eráti (Rádio Comunitária), Mogovolas (Rádio Comunitária de Iulute), Angoche (Rádio Comunitária Parapato), Moma (Rádio Comunitária Macone), Ribáuè (Rádio e Televisão Comunitária) and the community rádio of Mecubúri) to three in Meconta, Mogovolas, and Ribáuè.

As planned, we ended our collaboration with eight community theatre groups during FY6Q1 from the districts of Angoche, Eráti, Memba, Moma, Monapo, Nacala Porto, Nampula City, and Rapale due to funding restrictions.

Five community theatre groups collaborate with SCIP in Mecubúri, Malema, Ribáuè, Meconta, and Mogovolas districts, addressing specific health themes (HIV, Family Planning, Nutrition, WASH, Malaria, and Conservation Agriculture) during their performances according to the topic calendar. Actors facilitate small group discussions with audience members to clarify and consolidate information following the performance. The small group discussions are valuable as they provide a space for the audience to discuss the performance and relate it back to their own communities and behaviors.

There were 1,348 community theatre performances during FY6 addressing the following themes: FP (404), WASH (205), Malaria prevention (307), HIV/AIDS (379), conservation agriculture (43), and other topics (10).

PROMOTE BEHAVIOR CHANGE THROUGH THE COMMUNITY NETWORK

Community volunteers of the community health network conduct house visits in Intensive Districts to share preventive health messages based in IEC strategies, educating and encouraging individuals to monitor their progress in behavior change. Each animadora is responsible for training 8 groups of 10 volunteers in different health messages, with two weeks to reach each group. Volunteers then share the information with each of the 10 families to whom she is responsible. While the volunteers have already completed the lessons planned by the project, visits focused on revision and reinforcement of topics to encourage behavior change. Animadoras further support the families of chronically ill and OVCs, and conduct supervision to ensure families are receiving the health lessons. This strategy aims to mobilize the community to encourage behavior change for health and sanitation topics and to increase utilization of health services.

In FY6Q4 volunteers in Nampula City visited 23,034 households, sharing messages on HIV (causes, signs, prevention, and treatment). This number is low in comparison with previous quarters, due to the progressive phase out in the other intensive districts, which affected our capacity to collect data from CHWs as the animadoras and supervisors were no longer supported by SCIP. Over the course of FY6, at least 181,564 households were visited, benefitting from messages on malnutrition, FP (different methods and advantages of FP), diarrhea (causes, signs, prevention, and treatment), child health, and malaria (causes, signs, prevention, and treatment). During FY6Q1, house visits addressed diarrhea, child health (including prevention of malnutrition).

In FY6Q3, 37 animadoras in Nampula City were trained on how to facilitate small group HIV prevention (over three consecutive sessions) targeting adolescent girls between 10-14 years, focusing on adolescence, sexual and reproductive health rights of adolescents, HIV and AIDS, and STI prevention.

In FY6Q3, 392 adolescent girls participated in three HIV prevention sessions in 20 small groups, some of which were 10-11 year olds, and the remainder which were 12-14 year olds. It was more challenging to discuss the above themes with the 10-11 year olds. In FY6Q4, efforts focused on the 12-14 year olds. After this adjustment, the demand from mothers and family members for the participation of their daughters was increasing. 2,321 adolescent girls participated in three HIV prevention sessions during FY6Q4 in Nampula City.

The SCIP nutrition strategy is implemented in specific localities in six districts: Angoche, Meconta, Mogovolas, Monapo, Moma, and Murrupula. The quarterly cycle begins

TABLE 6. IMPLEMENTATION COVERAGE REACHED BY PROMOTORS AND ANIMADORAS IN NUTRITION DISTRICTS

		Initiated activities	# population covered per group	% of target (900,000)
P1	A1	March 2014	180,000	20%
	A2	April 2014	140,000	36%
P2	A1	August 2014	241,000	62%
	A2	October 2014	182,000	83%
P3	A1	November 2014	122,000	96%
	A2	January 2015	99,500	107%
Total general population involved to date			964,000	107%

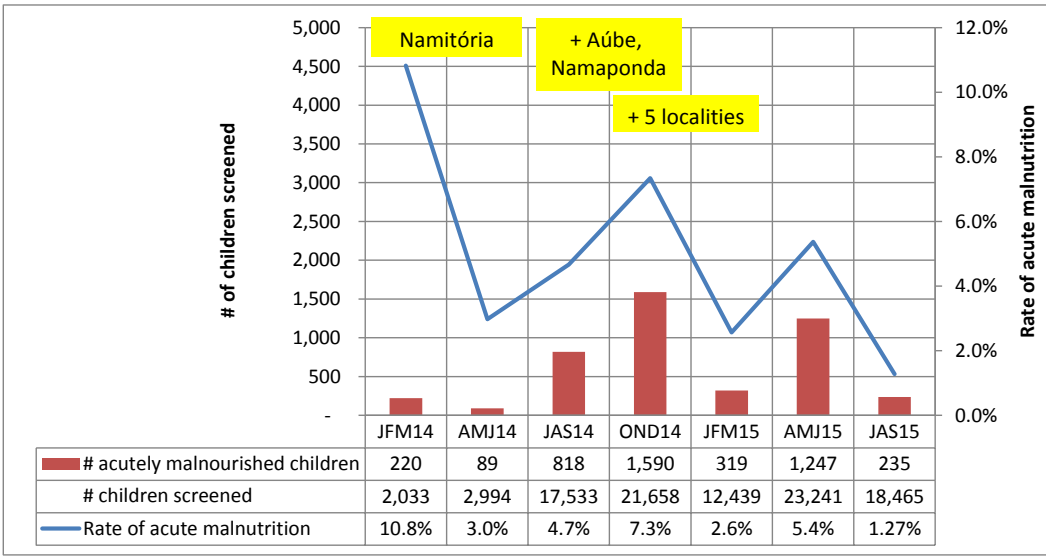
with animadoras and CLFs mobilizing the mothers of the target group (pregnant women and women with children under 5) to bring their children for a one-day acute malnutrition screening using the mid-upper arm circumference (MUAC) tape and assessment for bilateral edemas. Children are identified as healthy, moderately malnourished or severely malnourished. Both moderately malnourished and severely malnourished children are registered in the Follow-up Book for Malnourished Children (*Livro de Seguimento da Criança Malnutrida*) by the CLF. Severely malnourished children are immediately referred to the HF for clinical treatment. Moderately malnourished children (without diarrhea/other infectious disease) are referred to community nutrition rehabilitation groups (organized by the animadora), locally referred to as *lareira*.

The strategy was rolled out gradually, progressively working with more cohorts of children that we continue to follow throughout the duration of the project. There are three groups of promotors (P1, P2, and P3), and each promotor works with two groups of approximately 10 animadoras (A1 and A2). Each group of 10 animadoras covers a general population of approximately 4,500 individuals. Table 7 demonstrates our progress towards the target of reaching a general population of 900,000 by September 2015. During FY6Q1 we trained the last group of Promotors (P3) and their first group of animadoras (A1). Training was completed during FY6Q2 following the training of the second group of animadoras (A2).

During FY6Q4, 153,502 children were screened for acute malnutrition using MUAC tapes and assessment for bilateral edemas in six districts, a result of the community mobilization efforts of the animadoras and CLFs. Of these, 1,409 (1.82%) children 6-23 months and 933 (1.22%) children 24-59 months were identified as moderately acutely malnourished; 148 (0.19%) children 6-23 months and 71 (0.09%) children 24-59 months as severely acutely malnourished; and 13 (0.02%) 6-23 months and 5 (0.01%) 24-59 months) with bilateral edemas.

The following six charts illustrate the trends of acute malnutrition rates in each of the districts with Nutrition activities, as well as the expansion of implementation in specific localities.

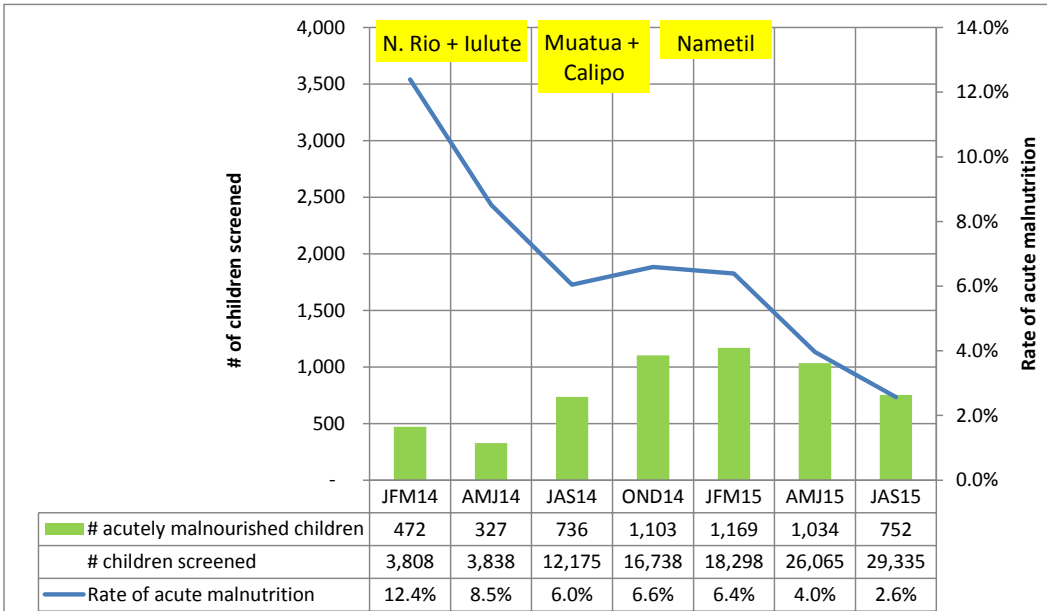
FIGURE 12. ACUTE MALNUTRITION TRENDS: ANGOCHE JAN 2014 - SEPT 2015



	JFM14	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	220	89	818	1,590	319	1,247	235
# children screened	2,033	2,994	17,533	21,658	12,439	23,241	18,465
Rate of acute malnutrition	10.8%	3.0%	4.7%	7.3%	2.6%	5.4%	1.27%

- The number of children screened has increased progressively from 2,033 in March 2014 to 21,658 in OND 2014 due to the expansion of geographic coverage reached by the community network. In JFM15, the number of children screened dropped to 12,439. Low participation was due to flooding resulting from extreme weather conditions. Participation was also reduced during JAS 2015 – particularly in Sangage (related to political tensions) and in Mepapata (food insecurity following floods).
- Overall, acute malnutrition rates seem to be reducing but should continue to be monitored, especially in the communities who did not participate in the screening of JAS15.

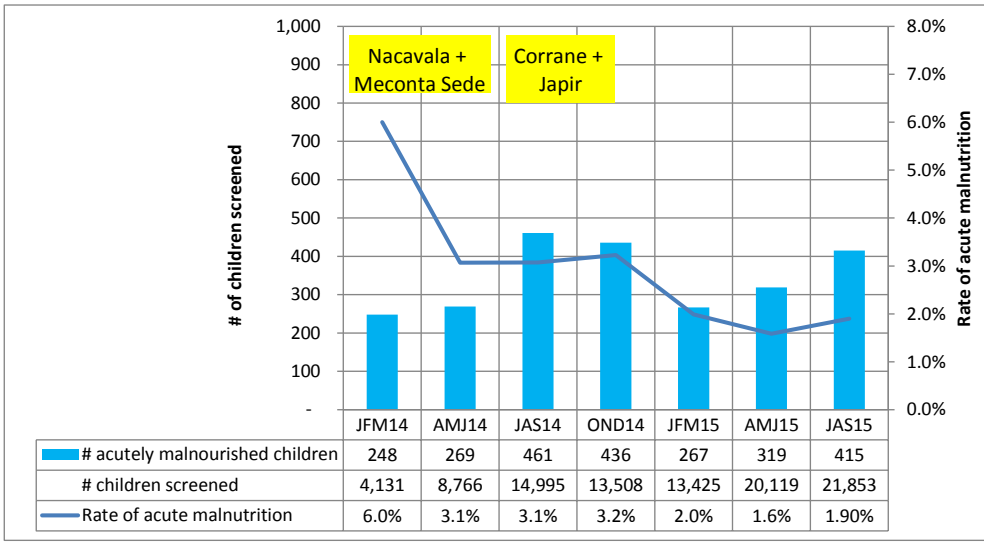
FIGURE 13. ACUTE MALNUTRITION: MOGOVOLAS JAN 2014 - SEPT 2015



	JFM14	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	472	327	736	1,103	1,169	1,034	752
# children screened	3,808	3,838	12,175	16,738	18,298	26,065	29,335
Rate of acute malnutrition	12.4%	8.5%	6.0%	6.6%	6.4%	4.0%	2.6%

- The number of children screened in Mogovolas has increased progressively from 3,808 in March 2014 to 29,335 in JAS 2015 due to the expansion of geographic coverage reached by the community network.
- Acute malnutrition rates have reduced consistently, from 12.4% to 2.6%.

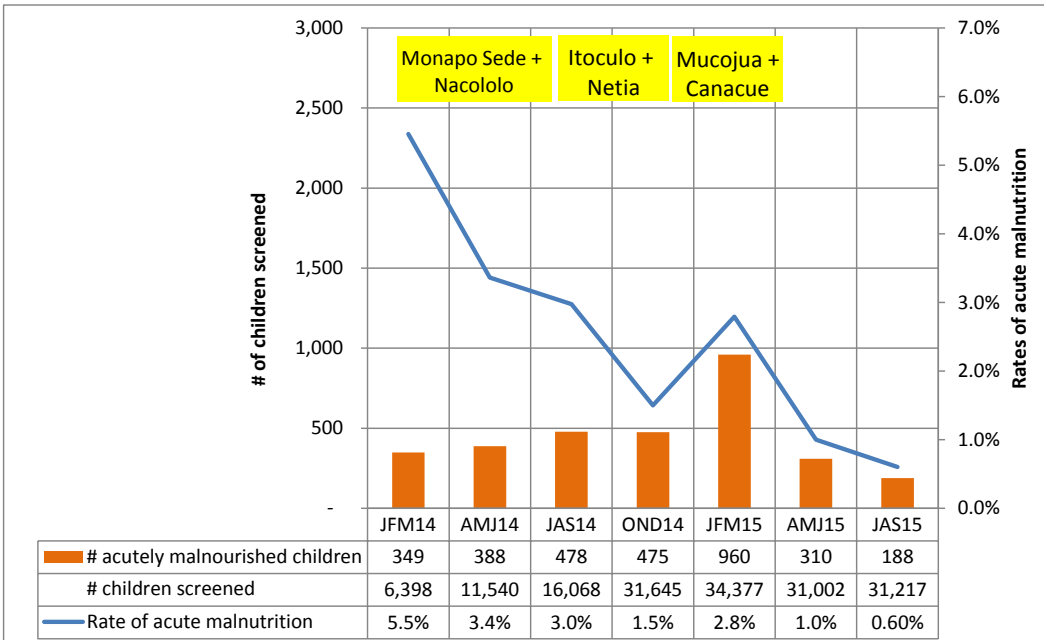
FIGURE 14. ACUTE MALNUTRITION: MECONTA JAN 2014 - SEPT 2015



	JFM14	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	248	269	461	436	267	319	415
# children screened	4,131	8,766	14,995	13,508	13,425	20,119	21,853
Rate of acute malnutrition	6.0%	3.1%	3.1%	3.2%	2.0%	1.6%	1.90%

- The number of children screened in Meconta has increased progressively from 4,131 in March 2014 to 21,853 in JAS 2015 due to the expansion of geographic coverage reached by the community network.
- Acute malnutrition rates have reduced consistently, from 6.0% to 2% in the last three quarters. As we approach the lean season, where food insecurity becomes more acute, it is expected that acute malnutrition rates will increase.

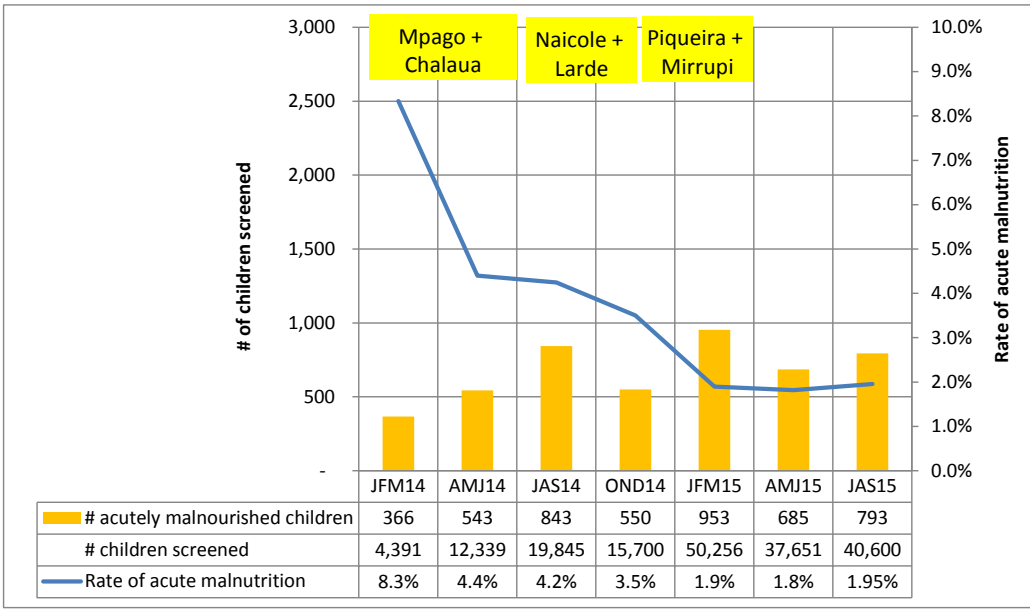
FIGURE 15. ACUTE MALNUTRITION: MONAPO JAN 2014 - SEPT 2015



	JFM14	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	349	388	478	475	960	310	188
# children screened	6,398	11,540	16,068	31,645	34,377	31,002	31,217
Rate of acute malnutrition	5.5%	3.4%	3.0%	1.5%	2.8%	1.0%	0.60%

- The number of children screened in Monapo has increased progressively from 6,398 in March 2014 to 34,377 in JFM 2015, consistent with the expansion of geographic coverage reached by the community network.
- Overall, the rates of acute malnutrition have decreased (from 5.5% to 0.6%). The peak observed during JFM15 falls within the lean season. Furthermore, nutrition activities began during JFM15 in the Mucojua locality, which reported an acute malnutrition rate of above 11%.

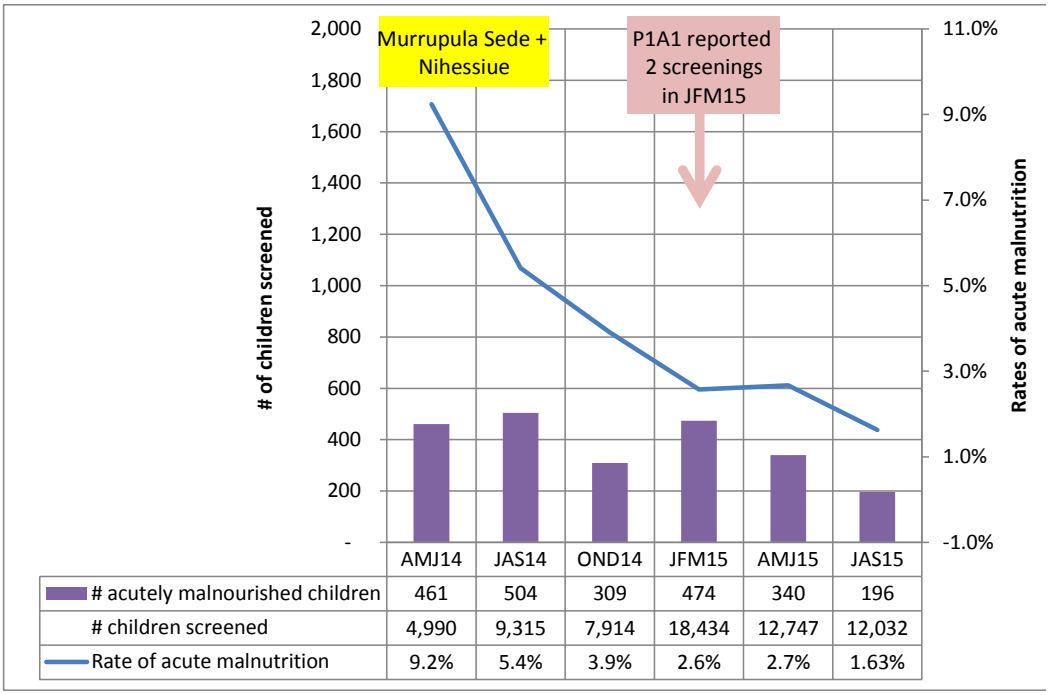
FIGURE 16. ACUTE MALNUTRITION: MOMA JAN 2014 - SEPT 2015



	JFM14	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	366	543	843	550	953	685	793
# children screened	4,391	12,339	19,845	15,700	50,256	37,651	40,600
Rate of acute malnutrition	8.3%	4.4%	4.2%	3.5%	1.9%	1.8%	1.95%

- The number of children screened in Moma has increased from 4,391 in March 2014 to around 40,600 in JAS 2015, with the progressive expansion of nutrition activities across six localities. In JFM15, one cohort of approximately 12,000 children (P2A1) was screened and reported two times during the quarter, explaining the peak of 50,256.
- The rates of acute malnutrition have decreased from 8.3%, stabilizing around 1.9% in the last three quarters.

FIGURE 17. ACUTE MALNUTRITION: MURRUPULA APR 2014 - SEPT 2015



	AMJ14	JAS14	OND14	JFM15	AMJ15	JAS15
# acutely malnourished children	461	504	309	474	340	196
# children screened	4,990	9,315	7,914	18,434	12,747	12,032
Rate of acute malnutrition	9.2%	5.4%	3.9%	2.6%	2.7%	1.63%

- In Murrupula, the number of children screened per quarter increased from 1,990 to 12,747. In JFM15, one cohort of approximately 5,200 children (P1A1) was screened and reported two times during the quarter, explaining the peak of 18,434.
- Acute malnutrition rates have decreased from 9.2% to 1.63% in JAS15.

Moderately malnourished children (without diarrhea/other infectious disease) are referred to community nutrition rehabilitation groups (organized by the animadora), locally referred to as *lareira*. The group meets six days a week for three weeks. Mothers learn to make enriched porridge using locally-available ingredients and feed their children. At the end of the three weeks the children are re-assessed with the MUAC tape. If the children are still moderately malnourished, they will repeat the *lareira* a second time. If at the end of the two *lareira* sessions the child has not improved, they are referred to the HF. *Lareira* attendance is recorded in the Follow up Book for Malnourished Children. Upon return to the community, severely malnourished children are also integrated into the *lareira* sessions. Mothers of over 13,446 children participated in *lareira* sessions during FY6.

Animadoras and CLFs visit the houses of malnourished children on a regular basis to follow the progress of the child and provide health counseling as needed – ensuring preventive measures are taken at the

household level and identifying potential barriers to improved nutrition. Activities during these visits are also recorded in the Follow-up Book for Malnourished Children. The screening sessions take place once a quarter in the same communities. The CLF is important during these house visits as they can convince a reluctant mother to participate in *lareira* or MUAC screenings.

In FY6Q4, 3,303 children identified as acutely malnourished during FY6Q3 were being followed up in the six districts. Of these, 2,786 (84%) received at least three visits in their homes over three months. 3,139 (93%) participated in the first *lareira* session, and 81% of these children made enough progress to graduate at the end of the three weeks. Seventy-six percent (76%) of children who participated in the second *lareira* graduated. Results suggest these efforts are paying off, as the malnutrition rates in consecutive MUAC screenings of the same groups of children are decreasing.

With respect to referrals to HFs, 311 (80%) acutely malnourished children identified through the MUAC tape (of the 369 identified during FY6Q3) were referred to the HF. Of these, 262 (84%) were confirmed as arrived (per the Child Health card). 41 (59%) out of 70 children identified with bilateral edemas were referred to the HF, and 37 (90%) were confirmed as arrived per the child health card. The majority of children identified with bilateral edemas during FY6Q3 were from Angoche (54), 48 of which were from the locality of Sangage, one of the last localities to be reached by the community nutrition intervention. Only 25 of these 48 were followed up during FY6Q4. There are two promotors working in Sangage, one who reported following up 19 out of 19 children identified with bilateral edemas, and the second who reported following up 6 out of 29. This second promotor is working in communities that are farther from the HF and which reported only one consolidated CLC during the mapping exercise.

In addition to the *lareira* groups, pregnant women and women with children under 5 years participate in mother education groups facilitated by the animadora. Each group has up to 20 mothers. Based in the same curriculum used in the intensive districts, each animadora shares nutrition and health education messages on a regular basis.

During the last quarter of FY6, community networks were “handed over” to their respective HFs, who will assume the aggregation and analysis of the community nutrition activities. This process will be further consolidated in November 2015, through a final refreshment exercise lead by HF providers with the support of SCIP and the Nutrition departments of DPS and SDSMAS.

The inclusion of an intensive nutrition strategy allowed the SCIP intervention to add one more result at the community level, addressing one of the major health concerns identified by communities, and building on community platforms and structures developed throughout the previous years. The nutrition training for the community network used a similar methodology as during the first activities at the community level. Malnutrition was contextualized within a broader framework of roots and causes as well as consequences, in order for participants to identify barriers and potential solutions to resolving this problem. Activities were designed in a way that allowed community members to see concrete results of their activities, and analyze their progress over time. The remaining challenge will be for communities to recognize the value of an effective community-HF linkage and an improved quality of

malnutrition treatment services provided at the HF level. Additionally, the HF should discuss the number of infant deaths due to acute malnutrition at the HF CMC meetings.

HIV TESTING AND COUNSELING SERVICES

In FY6, 30,377 individuals were counseled and tested, and received their HIV test results from HTC-C counselors. HTC-C counselors sensitize partners as to the importance of couple testing. In the reporting period, 18,192 individuals participated in an individual counseling session, 4,746 individuals were tested in a couple counseling session and 7,439 individuals were tested in a family session. 1,926 (6.3%) individuals tested HIV+.

Of the total 30,377 individuals tested for HIV, OVPs represented 52% (15,912/30,377), key populations 3.6% (1,091/30,377), and children of OVPs 20% (6,221/30,377). A priority for SCIP has been to identify HIV+ children and enroll them into treatment. Increasing adherence to HIV+ treatment plans for children has been highlighted as a priority focus in the Accelerated Treatment Plan of the MoH.

In FY6, 6,730 chronically ill individuals with unknown HIV status were tested for HIV, 790 (12%) of whom tested positive. The percent of chronically ill who are HIV+ has decreased as HTC-C counselors have broadened their focus, no longer concentrating exclusively on the most severely chronically ill. The approach targets families, including partners and children in testing and counselling activities. Those testing HIV+ are referred to the HF and confirmed at the HF level through a counter-referral.

We continued to focus on improving couples counseling and increasing outreach to partners and children of seropositive pregnant women identified through prenatal consults in the HF. After obtaining consent, HTC-C counselors visit the homes of the seropositive pregnant women to provide health counseling on various diseases, sanitation, community support and prevention. PwP messages are shared throughout the counselling. Partners and children are counseled and tested for HIV. SCIP aims to keep the pregnant woman in PMTCT services at the HF, and in the event the partner is HIV positive, that he is also integrated in care and treatment services. In FY6, 1,301 partners were tested for HIV during household visits, of whom 263 (20%) tested positive, highlighting the importance of continuing a

TABLE 7. DETAIL OF OVPS TESTED FOR HIV AND SEROPOSITIVITY RATES, BY GROUP

Reporting period	FY6Q1			FY6Q2			FY6Q3			FY6Q4		
Identified by community network and tested by HTC-C	Tested	HIV+	%	Tested	HIV+	%	Tested	HIV+	%	Tested	HIV+	%
# of partners of HIV+ pregnant women	243	57	**23**	437	101	**23**	372	63	**17**	249	42	**17**
# of chronically ill individuals	1,241	214	**17**	2,069	276	**13**	2,019	194	**10**	1,401	106	**8**
# of partners of chronically ill individuals	552	55	**10**	1,096	130	**12**	901	52	**6**	812	34	**4**
# OVCs	159	4	**3**	351	4	**1**	371	4	**1**	322	5	**2**
# non injecting drug users	42	4	**10**	44	5	**11**	6	2	**33**	7	2	**29**
# truck drivers	336	38	**11**	463	36	**8**	385	32	**8**	236	19	**8**
# migrant workers	393	28	**7**	450	22	**5**	574	13	**2**	381	18	**5**

comprehensive strategy for the family. See Table 8 for the details.

SCIP targeted key populations (SW, MSM) for testing and counseling services in areas not covered by the CDC Key Populations intervention. In FY6, 1,082 individuals of key populations were tested, of whom 89 (8%) tested positive. The majority of sex workers were tested in Malema, Ribáuè, Nacala Velha, Nacala Porto, and Moma – sites of major projects with mobile populations, commerce and transactional sex. See Table 9 to compare quarters in FY6.

FP booth at Mozambican Woman's Day

During FY6, the HTC-C team offered HIV testing and counseling services in outreach activities including:

- Health fairs for International Nurses Day, the Catholic University, Mozambican Women's Day, a breast cancer screening day;
- World AIDS day;
- At the penitentiary, the Health Sciences Institute, the Teacher Training Institute; and
- Four secondary schools in Nampula City.

SUPPORT THE UNIVERSAL ACCESS TO MALARIA PREVENTION PROGRAM

TABLE 8. DETAIL OF HIV TESTING FOR KEY POPULATIONS AND SEROPOSITIVITY RATES, BY GROUP

Reporting period	**FY6Q1**			**FY6Q2**			**FY6Q3**			**FY6Q4**		
HIV testing for Key populations	Tested	HIV+	**%**	Tested	HIV+	**%**	Tested	HIV+	**%**	Tested	HIV+	**%**
SW	238	26	**11**	299	25	**8**	267	11	**4**	200	17	**9**
MSM	18	2	**11**	59	5	**9**	5	1	**20**	5	2	**40**

SCIP continuously supports the transportation and distribution of mosquito nets from the district warehouse to the peripheral HFs. Malaria is discussed at the community level and many CLCs have been sensitized (in collaboration with the Malaria Consortium). SCIP encourages CLs to monitor the distribution and use of mosquito nets in their communities.

SUB-IR 4.2.2 IMPROVED COMMUNITY ENVIRONMENT TO SUPPORT HEALTHY BEHAVIORS

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
5.1 # of beneficiaries indirectly benefiting from other family members participating directly in savings groups (ASCA/VSLA) supported by the project (OVC)[R]	4,830	91%	2,954	3,529	4,093	4,393
	We achieved 91% of our target.					
5.2 # of direct participants in savings groups (ASCA/VSLA) supported by the project (OVC)[R]	2,415	100%	1,317	2,001	2,269	2,418
	We have met our target.					

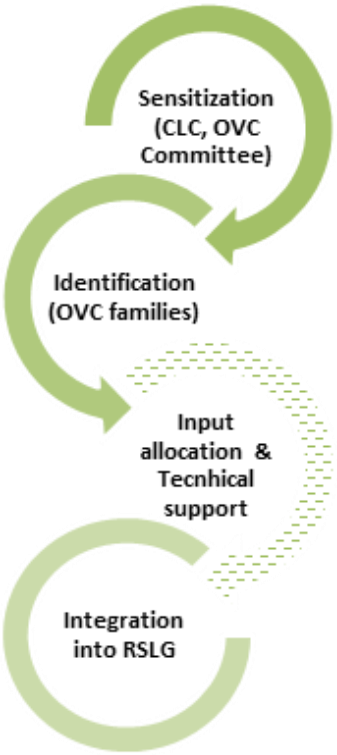
4.2.2.1 ADDRESS MAIN DETERMINANTS OF HEALTH INEQUITIES, INCLUDING GENDER ISSUES/GBV, FACTORS THAT INCREASE LTFU AMONG ARV USERS; AND OTHER FACTORS THAT AFFECT OVCS

ECONOMIC STRENGTHENING OF OVCS

The needs of OVCs continue to be addressed with a particular emphasis on providing economic development opportunities for older OVCs through savings and loan groups, supporting the delivery of the action plan for OVCs (PACOV). These activities are institutionalized as community services through the community network and other public service delivery channels by the CL OVC focal point's participation in CLCs, further fostering linkages with other community-based activities to increase OVC access to opportunities to better their futures.

Figure 18 shows the four main steps involved in the process of integrating OVC families into Rotating Savings and Loans Groups (RSLG): (a) community sensitization at the CLC level through OVC sub-committees; (b) identification of OVC families; (c) allocation of farming inputs (seeds and equipment) and technical assistance; and (d) integration of OVC families into RSLG (once the minimum funds necessary to contribute for RSLG membership are met). If the family already has the minimum necessary funds and are willing to contribute, they are immediately invited to join the existing RSLG.

FIGURE 18. PROCESS OF OVC INTEGRATION INTO RSLG



In order to integrate as many OVC families as possible in an Economic Strengthening activity, SCIP builds on existing community structures such as CLCs, OVC Sub-Committees, and Community RSLG. SCIP focuses first on areas where more community structures are active and collaborative: 1) communities with CLC and YFC and existing RSLG; 2) communities with CLC and YFC without RSLG – in this case, the CLC is used for RSLG inception, integrating OVC's families from the beginning; 3) communities with CLC and without YFC/RSLG, but with an existing RSLG in a neighboring community –in this case, inviting the

RSLG animator to help establish a new RSLG. OVC families are followed up throughout the different steps leading to their integration in RSLGs.

OVC sub-committees continue to be involved in identifying OVC families for integration in RSLGs. Some of the existing RSLGs reported completion of a savings cycle, and were able to divide the interest among members; OVC families used the funds to purchase zinc roofs, food and school materials for the children.

OVC families living under the poverty line have benefitted from agriculture inputs (depending on soil conditions of the family land) and technical assistance through the RSLG district assistant and the community monitor. A portion of the crops will be sold, the profit of which will be used to contribute to a local RSLG (to be established if there are none existing).

Over FY6, considerable efforts were carried out to include an additional 1,101 OVC families in RSLGs, corresponding to an additional 2,063 OVCs who benefit from economic strengthening activities (through inclusion in RSLGs). Table 10 summarizes the economic strengthening activities for OVCs to date.

TABLE 9. DISTRIBUTION OF ECONOMIC STRENGTHENING ACTIVITIES WITH OVCS

		Angoche	Eráti	Malema	Meconta	Mecubúri	Memba	Mogovolas	Moma	Monapo	Nacala Porto	Nacala Velha	Nampula City	Rapale	Ribáuè	Total
# OVC families identified for other economic opportunities		89	200	156	188	200	333	235	170	200		183	168	139	207	**2,468**
# OVC families benefiting from farming inputs		**109**	**142**	**156**	**104**	**154**	**216**	**108**	**143**	**176**	**101**	**151**	**132**	**94**	**200**	**1,986**
# OVC beneficiaries (farming inputs)	**Male**	98	139	155	120	248	189	76	112	200	65	88	145	143	183	**1,961**
	Female	58	133	147	82	252	170	60	79	172	73	75	110	119	175	**1,705**
	Total	156	272	302	202	500	359	136	191	372	138	163	255	262	358	**3,666**
# OVC families in RSLGs		**117**	**217**	**166**	**188**	**193**	**214**	**207**	**220**	**200**	**67**	**186**	**152**	**84**	**207**	**2,418**
# OVC beneficiaries (RSLG)	**Male**	146	207	155	166	241	165	162	175	172	88	194	145	162	177	**2,355**
	Female	29	195	147	113	248	162	161	117	165	75	160	152	146	168	**2,038**
	Total	**175**	**402**	**302**	**279**	**489**	**327**	**323**	**292**	**337**	**163**	**354**	**297**	**308**	**345**	**4,393**

ENABLING COMMUNITY STRUCTURES TO DIMINISH HEALTH INEQUITIES

SCIP has many activities aiming to reduce the inequities in gender and inequities related to the most vulnerable populations, for example:

- Continuous support provided to CLFs in Nutrition, in order to reduce stigma and discrimination related to malnutrition at the community level, to improve support for families with a malnourished child and facilitate identification of roots of malnutrition as well as develop action plans to improve conditions, identification and support for those who are not participating in nutrition activities because they are uncomfortable with the nutritional status of their child. In the 37 localities identified to receive the specialized nutrition package SCIP has trained at least 1 CLF and 1 trained animadora per community.
- In Sangage and Mepapata localities of Angoche, programmatic data showed elevated and increasing rates of moderate and severe acute malnutrition in children between 6-59 months over the last quarters. In Sangage, the SCIP and the district responsible Nutrition officer confirmed that in fact, the community network experienced significant barriers to work in their communities –resistance from some community members inhibited sensitization and nutrition screening activities, despite the efforts of the community leader facilitators. Animadoras feared being attacked, and one of the Promotors was robbed after receiving his bicycle from the project. The Chefe of the locality called a meeting, inviting neighborhood secretaries, traditional leaders (régulo), and religious leaders to discuss the challenges experienced by the animadoras. The animadoras also participated in this meeting. Data from the nutrition activities of the previous quarters was shared in order to show the severity of the problem and that it was across all animadoras. Community leaders expressed that it was a few vocal members of the community that provoked the broader resistance. They also requested additional support through trainings to be able to address these issues in their communities. During the last visit, animadoras and CLFs reported that the situation had improved, following specific sensitization efforts with the community members who were preventing the community intervention.
- In Mepapata, the high rates of acute malnutrition were related to food insecurity caused by the floods of FY6Q2 – families were unable to prepare the enriched porridge for their children. After verifying the data – assessing technical skills of animadoras in using the MUAC tape, completion of monitoring instruments, verification of recommended procedures after identifying acutely malnourished children, the team recommended that the MCH nurse of Namaponda HF return to the community with PlumpyNut for the nutritional rehabilitation of both the moderately and acutely malnourished children, which took place the following week. Follow up visits needed to be done at Namaponda HF, 17 km from Mepapata. This is a significant barrier to ensuring that children complete follow up. The District food security task force of Angoche was sensitized in order to be more responsive to the identified needs of this population.
- Training and continuous support provided to CLFs in Male Involvement for Sexual and Reproductive Health in order to create an enabling community environment for access of women to FP/HIV and institutional deliveries through facilitating small group discussions on gender, decision-making agency, gender-based violence and their effect on health outcomes

and behaviors. During FY6, community discussions were held by community leader facilitators. In Nampula City, male involvement activities run in parallel with the Afternoon of the Woman as a way to integrate males in the hot topics surrounding health of women and children. Community leader facilitators also continue community discussions on male involvement in SRH, focusing on promoting FP in their respective communities.

- Training and continuous support provided to CLFs in the CoC in order to reduce stigma and discrimination at the community level as well as to foster an encouraging environment for chronically ill individuals to remain on treatment;
- Training and continuous support provided to 183 OVC sub-committees in order to assist animadoras and volunteers in overcoming barriers in assisting OVCs, facilitate the links between formal and informal institutions and promoting discussion/action plans to improve accessibility to community and institutional services such as education, health, RSLG, etc. During the last quarters of FY6, efforts focused on strengthening the linkages between the community and institutional service providers. In Nampula City, these activities took place in July and August 2015, consolidating the relationship between 17 OVC sub-committees and local government institutions in order to continue supporting OVCs to receive PACOV services.

COMMUNITY SUPPORT FOR CHRONICALLY ILL (INCLUDING HIV+) PATIENTS

Home-based care (HBC) for chronically ill patients is provided in all districts of the SCIP project, with the objectives of reducing the suffering of chronically ill patients, reducing stigma and increasing adherence to treatment and HF consults. Chronically ill patients are identified by community leaders, APEs, HTC-C counselors and community health activists during their regular house visits, and are defined (per the MoH) as individuals who are affected by one of the following diseases: HIV/AIDS, tuberculosis, leprosy, hypertension, and epilepsy. Activists educate caregivers on how to care for chronically ill family members and share messages on adherence to treatment, nutrition, hygiene and other aspects that will benefit the patient and family.

During FY6, 7,522 chronically ill were followed up by animadoras, APEs and HTC-Cs including psychosocial and spiritual support, monitoring of adherence to treatment and care services, referrals for treatment of opportunistic infections and other HIV/AIDS-related complications, nutritional counseling and training and support for caregivers.

Of the chronically ill followed up during FY6, 5,296 were confirmed as HIV+, 4,561 were on ART, 729 on Cotrimoxazole, 647 were on tuberculosis treatment and 82 were seropositive pregnant women.

During FY6, 30 counselors, 240 animadoras and 338 APEs provided the seven services of Positive Prevention in their regular follow up visits to households of HIV+ individuals. The community network strengthens the link between clients and health services through participation in HF Co-Management meetings and clinical HF committees, referrals, verification of counter-referrals and discussion with providers as needed.

During FY6Q3 & FY6Q4, joint supervision visits (the Provincial Responsible Officer for the APE program, the Provincial Responsible Officer for HIV, the Provincial SCIP supervisor and M&E officer) took place in

Eráti, Murrupula, Nacala Velha, Memba, Monapo, Meconta, and Angoche. The purpose of the visits focused on the following:

1. Participation of APEs in the monthly ART follow-up meeting at the HF;
2. Handover management, follow up, and discussion of data of the *Livro de Seguimento de Doentes Crónicos* completed by the APE to the HF HIV focal point;
3. During district APE and/or HIV supervisor visits to the peripheral HFs, attention will be given to supervise HBC carried out by APEs at the community level.

In Nampula City, during FY6Q4, specific efforts were dedicated to carry out meetings between animadoras and the ART Responsible officer at each HF in order to strengthen the sustainability of linkages between the community and the HF: that the HF continues to provide lists of defaulters for active search to animadoras, that animadoras continue to provide HBC services and report to their respective HFs.

4.3 STRENGTHENED SYSTEMS TO DELIVER HEALTH, NUTRITION, AND SOCIAL SERVICES

SUB-IR 4.3.2 IMPROVED LOGISTICS MANAGEMENT OF COMMODITIES TO ENSURE AVAILABILITY AT LOCAL LEVELS

4.3.2.1 SUPPORT HEALTH SYSTEMS STRENGTHENING FOR MANAGEMENT AND LOGISTICS FOCUSING ON PERIPHERAL HEALTH UNITS

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
% of USG-assisted SDP experiencing stock-outs of specific tracer drugs	Access remains limited, especially to the more peripheral HFs, especially during April and May.					
# Health facilities assessed			63	86	92	77
6.1 # (%) with stock out of first line antimalarial drugs (Coarten)	15%	10%	6 (10%)	17 (19%)	13 (14%)	8 (10%)
6.2 # (%) with stock out of oral contraceptives	3%	3%	1 (2%)	7 (8%)	8 (9%)	2 (3%)

Indicators 6.1 & 6.2, the number of USG-assisted SDP experiencing stock-out of specific tracer drugs, measures product availability (or lack thereof), and serves as a proxy indicator of the ability of a program to meet clients' needs with a full range of products and services. SCIP has a rolling monitoring system and cannot capture all 143 units every quarter. In FY6 SCIP tracks availability of first-line anti-malaria drugs (Indicator 6.1) and stock out of oral contraceptives (Indicator 6.2).

SUB-IR 4.3.3 STRENGTHENED CIVIL SOCIETY ENGAGEMENT IN THE HEALTH SECTOR

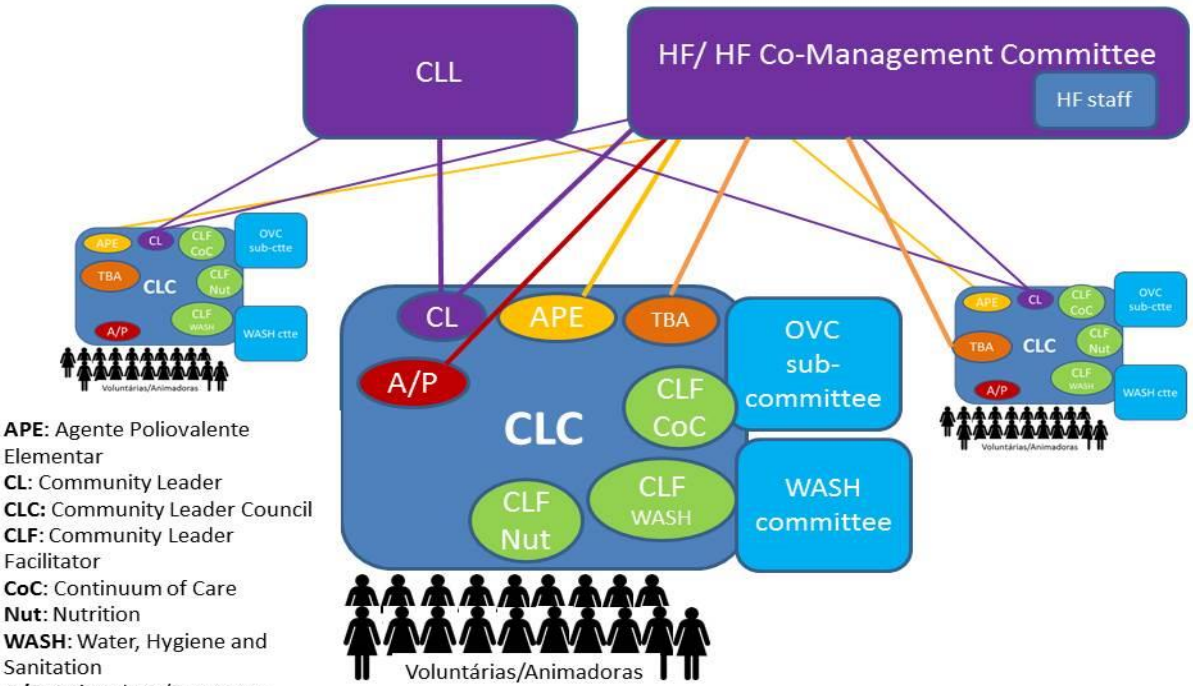
4.3.3.1 CONSOLIDATE COMMUNITY PARTICIPATION AT HEALTH SYSTEM LEVELS: PLANNING, BUDGETING, ACCESS TO SUPPLY, AND GOVERNANCE TO ADVANCE THEM TOWARDS SUSTAINABILITY

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
7.1 # of community groups developed and supported	1,270	111%	1,291	1,285	1,332	1,406
	We have met our target for FY6. These community groups were confirmed through the mapping exercise.					
CLCs			919	919	966	1,036
Water Committees			371	366	366	370
7.2 % of HFs that meet with CLC representatives at least quarterly to evaluate health issues (#=139)	84%	68%	58%	50%	56%	68%
	95 out of 139 HF CMCs (68%) met during FY6Q4. While this number has improved over the course of the year, we did not meet our target.					

PROVIDE TECHNICAL SUPPORT TO HEALTH FACILTY CO-MANAGEMENT COMMITTEES (HF CMCS)

HF CMCs work to improve service quality and strengthen the health system both at the HF and at the community levels. As represented in Figure 19, HF CMCs are composed of CLC representatives, nurses, HF head, HF staff, *agentes polivalentes elementares* (APEs), traditional birth attendants (TBAs) and *animadoras*.

FIGURE 19. COMMUNITY NETWORK ACTORS AND THEIR LINKS WITH LOCALITY STRUCTURES



APE: Agente Poliovalente Elementar
CL: Community Leader
CLC: Community Leader Council
CLF: Community Leader Facilitator
CoC: Continuum of Care
Nut: Nutrition
WASH: Water, Hygiene and Sanitation
A/P: Animadora/Promotor
CLL: Conselho Local da Localidade
TBA: Traditional Birth Attendant
HF: Health Facility

HF CMCs organize community network and CLC activities to support increasing coverage and health indicator achievement. The participation of local CLs in these meetings has a leading role in strengthening accountability of the HF to the communities it serves. HF CMC meetings are a forum for committee members to propose activities to improve health indicators of their communities, share information such as upcoming mobile brigades, analyze health data, provide feedback on quality of care, and provide a space for *animadoras* to present challenges they face in their work. Also during these meetings, providers can share the difficulties they have in meeting health targets and members work together to find local solutions for challenges. 97 HF CMCs (out of 139) met in FY6Q4. Of the 1,036 CLCs who participated in the survey and mapping exercise, 73% (757) reported participating in their local HF CMC meeting.

INCREASE INVOLVEMENT AND LEADERSHIP OF CLCS

Analysis of data collected by volunteers in their communities is important for the resolution of identified problems. These monthly CLC meetings help leaders assess the health status of their communities: what are the problems; if there are any changes or not; and what they can do to promote the change they wish to see. The CLC monitoring book (recording details of each specific CLC, expected numbers for various health indicators - i.e. deliveries, FP clients, children for vaccination, as well as achievements during the month for MCH, CoC, FP, activities of the community network, community access to water and hygiene and sanitation conditions, community support provided for OVCs and the wider community) was piloted during FY6Q1 was distributed to districts during FY6Q2. These forms are aggregated and reported quarterly to the HF to be analyzed by the HF CMC, and to the head of the locality to be analyzed at the CLL meeting. 131 CLCs from eight districts reported on CLC activities during FY6Q3, and 258 CLCs from eleven districts reported on activities during FY6Q4.

Many communities have benefited from at least one of SCIP's community activities over the course of the project. Knowing this, we were interested to know how many of these communities were currently active and in which way they were active. As such, SCIP repeated the mapping exercise of activities in the 15 districts during FY6Q3, mapping confirmed "active" CLCs and their activities as shown in Table 11. This activity served to provide a snapshot of the current level of maturity and functionality of the CLC structures and as well as the degree of multisectorality.

TABLE 10. RESULTS FROM COMMUNITY MAPPING AMJ15

Domain	Number of CLCs (%)
Good governance	
Reported meeting at least once in the past 3 months	863 (83%)
Participate in the *Conselho Local da Localidade*	818 (79%)
Has a book to register minutes from CLC meetings	856 (83%)
Health	
Participate in the HF CMC	757 (73%)
Has a CLF in Male Involvement in SRH	633 (61%)
Animadoras regularly share community health data with CLC	905 (87%)
WASH	
Has a CLF in CLTS	757 (73%)
Has a potable water source	573 (55%)
Has a water management book	468 (82%)
Community members contribute funds for maintenance	484 (84%)
Agriculture	
Reported having an agricultural association and/or a youth farmer club	370 (36%)
Total number of CLCs mapped & interviewed	1,036

SUPPORT SEMI-ANNUAL CLL MEETINGS TO MONITOR CLC ACTIVITIES

The CLL – *Conselho Local da Localidade* – is a body representing peripheral communities led by a public functionary, who is a representative of the state in this subarea. In the SCIP community involvement strategy, focusing on the CLL increases the sustainability of the activities supported at the different CLCs. The review of CLC activities by the CLL shows the degree to which CLs and the community network are involved and the role they play in influencing behavior change in their own community.

CLLs hold biannual meetings during which the issues of the diverse range of actors in the community network (CLC presidents, animadoras, TBAs, Water Committee presidents, YFC Monitors and CL facilitators) are discussed. SCIP provided technical assistance to the *Chefes das Localidades* for the preparation of 88 review meetings during FY6.

INCREASING COMMUNITY INVOLVEMENT FOLLOW UP THROUGH CIVIL SERVANTS AT THE PERIPHERAL LEVEL

During FY6Q4, 463 locality and administrative post chiefs (including other relevant government technicians) participated in a two day training facilitated by SCIP, SDSMAS & SDPI, and the *Secretarias Distritaís.* This activity consolidated knowledge and skills developed over the past five years working together with SCIP in a broad range of community development topics, and strengthened capacity to monitor and follow up progress achieved in the geographic region for which they are responsible. Topics addressed included water, hygiene, and environmental sanitation (increasing access to potable water, the role of the water committee and the importance of public accountability processes); health & social services (OVCs, continuum of care for chronically ill, family planning, nutrition, institutional deliveries, the role of the HF CMC president).

GUIÃO PARA FACILITAR A COORDENAÇÃO E IMPLEMENTAÇÃO DE PLANOS DE ACÇÃO MULTISSECTORIAL DAS LOCALIDADES PELOS CHEFES DE LOCALIDADE, SECRETÁRIOS E CHEFES DE POSTOS ADMINISTRATIVOS

Elaborado com o apoio técnico do SCIP, projecto de base comunitária visando o fortalecimento e desenvolvimento integrado das comunidades e financiado pela USAID

Given the importance of this step for future sustainability of community involvement activities, the manual was reviewed and endorsed by the *Secretaria Provincial* of Nampula. Trainings were held in each district, with the participation of the technician of the Planning Department of the *Secretaria Provincial*.

SUPPORT QUARTERLY TECHNICAL MEETINGS OF CLFS: CLTS, GBV, CONTINUUM OF CARE, MALE INVOLVEMENT, NUTRITION

SCIP has dedicated specific attention to encouraging the realization of regular quarterly half-day meetings at the administrative post (locality level when possible). These meetings involve the secretary, the head of the locality and an appropriate provider from the HF, according to the type of CLF. For example, for CLTS CLFs, the preventive medicine technician is invited. During these meetings CLFs discuss the challenges they face in their communities and share strategies to overcome these barriers.

For CLTS CLFs, SCIP introduced a programmatic table to highlight the progress achieved (by quarter) in communities in order to reach Open-Defecation Free status (i.e. number of existing latrines, number of new latrines constructed, number of garbage pits, number of dish drying racks, number of TipTaps). This table was included in the training for the *Chefes das Localidades* referred to above.

SUB-IR 4.3.4 IMPROVED GENERATION, DISSEMINATION, AND USE OF HEALTH DATA FOR MORE EFFECTIVE DECISION MAKING

Indicator	Annual Target	Achieved Y6	Achieved by quarter			
			Q1	Q2	Q3	Q4
8.1 % HFs reporting routine malaria data on time[R] (N: # of HFs reporting malaria data on time; D: # of total HFs in province) (malaria)		93%	84%	89%	93%	84%
	144 out of 172 HFs reported routine malaria data on time during FY6Q4.					
8.2 % APEs reporting routine malaria data on time[R] (N: # of APEs reporting malaria data on time; D: # of total APEs in province) (malaria)		90%	25%	60%	90%	91%
	430 out of 473 APEs reported routine malaria data on time during FY6Q4. This progress is encouraging.					
8.3 % of districts reporting routine malaria data on time[R] **(**N: # of districts reporting malaria data on time; D: # of total districts in province) (malaria)		100%	77%	40%	100%	100%
	15 out of 15 districts reported routine malaria data on time to DPS.					

4.3.4.1 IMPROVE DATA COLLECTION AT COMMUNITY AND HEALTH FACILITY LEVEL, PROCESSING ANALYSIS AND DECISION MAKING PROCESS WHICH ALSO INCLUDES REGULAR MONITORING OF STRATEGIES AND MENTORSHIP

PROVIDE TECHNICAL ASSISTANCE AND SUPPORT TO SDSMAS

Collaboration between SDSMAS and partners at the district level is crucial, facilitating the exchange of ideas, joint planning and ensuring the most efficient allocation of resources. Coordination meetings are led by SDSMAS on a regular basis. Support for these meetings rotates between partners. SCIP district teams continue to support the aggregation and analysis of health data, problem solving, monthly planning and logistics for these meetings.

New data collection tools for malaria were introduced in 2014, which should enable providers to better report activities. Unfortunately, the forms are not being used in all HF, and providers have difficulties in correctly reporting information. In FY6Q3, SCIP supported a training in Nampula City to address these challenges with 37 malaria technicians. District SCIP teams further supported supervision visits in Nampula City and Ribáuè to improve program management. A Provincial SCIP team visited five districts (Nacala Velha, Eráti, Memba, Monapo, and Murrupula) providing technical assistance to APEs and HF staff to improve malaria data collection. Malaria focal points of Eráti and Nacala Velha held meetings (with SCIP support) with providers to improve completion of malaria monitoring forms.

In FY6, SCIP supported coordination meetings with SDSMAS and local NGOs reviewing the activities of previous quarters and planning for upcoming quarters in Meconta, Nampula City, Monapo, Eráti and Nacala Velha.

SDSMAS data review meetings are held monthly (including the routine malaria indicators) with SCIP providing logistics and technical support (i.e. production of graphs by HF catchment area for the

following indicators: # children completely vaccinated, # institutional deliveries, # first pre-natal consults tested for HIV, CYP). These graphs facilitate the analysis of health indicators and the analysis of performance by HF in the 15 SCIP districts. When requested, SCIP supports SDSMAS with office material.

Health partners of DPS continue to meet monthly through the NGO and association forum. The secretary is led by SCIP, N´weti and AIFO, and facilitates the communication flow between DPS and the partners.

FACILITATE SHARING OF HF DATA WITH THE HF CMCS

Please see Section 4.3.4.1: Provide technical support to HF CMCs.

TECHNICAL SUPPORT PROVIDED FOR MATERNAL AND NEONATAL MORTALITY AUDIT COMMITTEES

SCIP supports regular meetings to discuss maternal and neonatal mortality, which are held at the beginning of each quarter.

FIGURE 20. MATERNAL MORTALITY IN NAMPULA PROVINCE, 2010-2015 (DPS DATA)

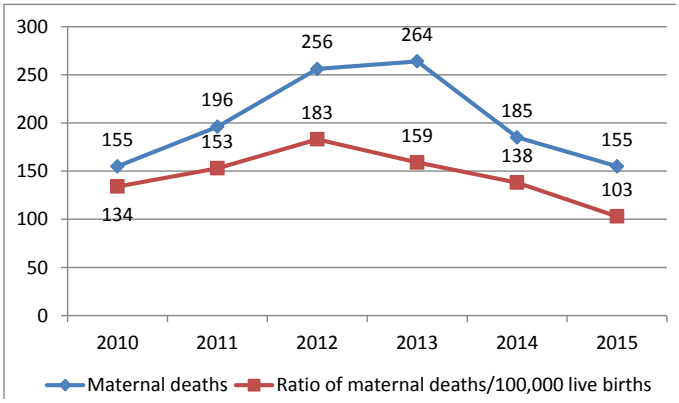


Figure 20 shows the trends in the number and ratio of institutional maternal mortality in Nampula Province (DPS presentation for the *Plano Economico Social* review meeting, September 2015). It is important to compare this with the graph of institutional delivery coverage. Despite increases in coverage from 58% in FY2 (2011) to 86% in FY6 (2015), and the increasing number of institutional deliveries from 23,278 to 45,427, the number of maternal deaths has returned to the number observed in 2010. When the coverage is increasing rapidly (+11% FY3, +7% FY4), the ratio of maternal mortality is expected to increase, especially when health services are not prepared for such significant increases (i.e. human resources, supplies, medication…). This graph shows that the national health system was successfully able to absorb this increase and re-establish the previous maternal mortality ratio.

PROGRAM MANAGEMENT

As SCIP in is the last year of the project, reduction of staff took place throughout the year and will carry on progressively throughout the October-November-December quarter. For the January-February-March period, only administrative oversight and closeout follow-up staff will be retained.

SCIP has reduced some positions during FY6Q1, including two senior district coordinator positions in Malema and Moma. In Malema the DMEO assumed both roles for the remaining period. In Moma, the project officer of Chalaua assumed the district coordinator position of Moma. Three senior district coordinator positions in Angoche, Ribáuè, and Mecubúri were reduced in FY6Q2. In Angoche the DMEO

took over both roles for the remaining period. In Ribáuè, a provincial nurse supervisor supported the phasing out process from FY6Q3. In Mecubúri, the district coordinator of Rapale transferred to Mecubúri while the DMEO of Rapale assumed the district coordinator position. Two DMEOs from Nacala Velha and Memba resigned during FY6Q4, with tasks shifting to the district coordinators.

In May 2015, the teams from CLUSA (YFC/RSLG manager, the provincial supervisor and the YFC/RSLG district assistants) and World Relief (two provincial community supervisors, 28 district supervisors, one human resources assistant) were let go. The World Relief manager will stay with the project until the end of November, looking after nutrition, APE, HBC & OVC activities. Five district community officers and one senior family planning officer concluded their contract in September 2015.

The HTC-C team was reduced from 39 to 28 counselors in FY6Q1, from 28 to 27 counselors in FY6Q2, from 27 to 21 counselors in FY6Q3, and the remaining 21 concluded their contracts in September 2015.

Animadoras in Intensive districts were reduced from 357 to 240 during FY6Q1 as part of the second phase out stage, 200 animadoras finished in April 2015, and the remaining 40 animadoras in September 2015. The respective supervisors were also let go.

In addition, the construction and rehabilitation engineer, the finance coordinator, the procurement officer, a Human Resources assistant, and a financial assistant left the SCIP team during FY6Q1. Two additional finance positions were terminated in September 2015.

SCIP undertook and submitted the yearly PEPFAR expenditure analysis in November 2014.

The purchase of nine new project cars was finalized during FY6Q1, in substitution of old vehicles that were expensive to maintain. Concomitantly, the fleet of motorbikes and vehicles has been reduced.

SCIP underwent an internal audit at the end of June 2015. The audit focused on financial procedures, inventories, car management, and human resource files.

SCIP rolled out payments using the mPesa mobile banking system of Vodacom during FY6Q2. This system allows direct payment to beneficiaries who have a mobile phone, significantly changing the way payments are distributed. Limitations emerged during the roll out, specifically the low cash availability at rural mPesa agents, the need to have mobile network to both confirm the phone number and for the beneficiary to receive the message. The more rural the beneficiaries are located, the less easy it is to implement.

From an administrative and logistic perspective, a phase out plan was elaborated in June to be progressively implemented throughout December 2015. Tasks include inventory follow up, selling of vehicles (already authorized for re-sale by USAID), conclusion of contracts (office rentals, service providers), standardization of project documentation at the district & provincial level, preparation of offices to be returned to their owners, etc.

MONITORING AND EVALUATION OVERVIEW AND ANALYSIS UPDATE

In October 2014, the SCIP team carried out the annual work plan workshop with Provincial and District teams, introducing the cost-extension activities and indicators. Subsequently, each district elaborated their own work plan for FY6 for operationality and phase out.

Additionally, M&E tools were adjusted to meet the requirements of the new (or revised) indicators. Specific efforts were made to develop an OVC logbook, a CLC monitoring book and a Referral/Counter-referral book for the community to the HF and vice versa. Existing HTC-C instruments were adapted to disaggregate data according to the new categories for OVPs. In order to fulfill the obligations for PEPFAR indicator SBRP.07/08, a new tool was developed to track nominally small group participants in HIV prevention topics for adolescent girls between 10-14 years old.

INSTITUTIONAL DELIVERY STUDY

The operational research to better understand the trends in institutional deliveries continued in FY6. The in-depth, qualitative phase of this research was approved by the Mozambican Bioethics Committee and fieldwork (in-depth, semi-structured interviews with key informants to better understand the motivations and the characteristics of the context which encourage adoption of institutional deliveries) began at the end of FY6Q3. A team of interviewers and Portuguese-eMakhuwa translators interviewed MCH nurses and HF staff, TBAs, community leaders and women who delivered in the HF in the catchment areas of Muatua (Mogovolas) and Nametoria (Angoche). Analysis of interview content began in FY6Q4.

OVC DATA QUALITY ASSESSMENT

At the request of USAID, M-SIP (Mozambique Strategic Information Project) conducted an OVC data quality assessment during September 2015, looking specifically at the consistency of the data reported between the service delivery point, the intermediary point, and at the central level. The assessment also evaluated the data management system and reports generated at each level. In general the results from the assessment were positive, with minimal differences in data reported between the service delivery point, the district level, and the central level databases. One recommendation was to create a database to follow each individual OVC, an unrealistic recommendation given the number of OVCs (around 40,000) benefitting from services and the capacity of the community network.

FOLLOW UP OF SCIP ENDLINE

Results from the SCIP Endline survey were presented to and discussed with USAID staff in the beginning of June, and was presented at the *Conselho Coordenador Provincial* in July 2015.

MAPPING SCIP ACTIVITIES

SCIP repeated the mapping exercise of activities in the 15 districts during FY6Q3: mapping active CLCs (if they have had Hot Topics discussions, participation in the CLL, regularity of meetings, participation in the HF CMC, CLFs), existence of bicycle ambulances, water committees (water source, existence of a management book, contributions made), TBAs, YFCs, and agricultural associations. Field work took place between the end of May and the beginning of June. Data is under analysis and the findings will be shared next quarter.

DEMO-CLTS STUDY - EAWAG

SCIP hosted the Swiss Federal Institute of Aquatic Science and Technology (EAWAG) for a study looking at CLTS programs between July-August 2015, working in Monapo, Meconta, Mogovolas, and Angoche. The objective is to determine which elements of CLTS are highly efficient to decrease Open Defecation (OD), which ones have no effects, which ones are hindering the decrease of OD, and which variation of CLTS is most efficient in supporting communities to reach open defecation free status. In addition, the mode of functioning of CLTS is under investigation, and an evidence-based behavior change approach (RANAS Model) is employed to identify the most effective behavior change strategies to decrease OD.
The survey was conducted in 600 households, and asked questions about latrine use, sanitation behavior, norms, and participation in CLTS.

USG FP AND USAID ENVIRONMENTAL COMPLIANCE

Attention was given for programmatic compliances while implementing SCIP project activities during the reporting period. The following are some of the key activities performed in relation to compliance for FY6:

- Providers received training in waste disposal (particularly contraceptives), infection prevention, and commodities storage during mentoring activities in 69 HF. This is a routine part of the mentoring activities.
- There were 36 integrated SDSMAS supervision visits in six districts (Malema, Rapale, Memba, Nacala Velha, Moma and Eráti) during which healthcare waste management was addressed.
- Healthcare waste was addressed during two quarterly HCT-C counselor anti-stress meetings.
- Waste generated from HIV counseling and testing was disposed of in compliance with USAID sector guidelines on healthcare waste during the health fairs in Meconta, Nampula City, Nacala Velha, & Monapo.
- All District Coordinators and M&E officers participated in a technical update in USG FP during the quarterly management meeting in May 2015.

**Pathfinder International is committed to full compliance with the USG Tiahrt Amendment and USAID Environmental Compliance and all other USG legislative and policy requirements in its USG-funded C/FP projects throughout the world. We are committed to the thorough monitoring of Tiahrt Amendment compliance at Pathfinder government- and NGO-implemented projects. Pathfinder believes that volunteerism and informed choice are an essential component of all C/FP programs.